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MENTAL HYGIENE

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SOME ASPECTS OF EDUCATION AND TRAINING IN RELATION TO MENTAL DISORDER*

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WE ARE met to fulfil the behest of one of the most distinguished physicians of psychological medicine of recent times. Maudsley was a leader in his lifetime, and he lit a lamp for research which it is our duty and that of the generations that follow after to keep burning. He was a man with a great insight and practical withal, for he has left behind him benefactions which are endowed by his inspiration and which must live with increasing benefit to mankind. The acuteness of Maudsley's vision is demonstrated by the method in which he founded these lectures; he perceived, and perceived rightly, that mental disorder was not purely a medical problem, but that there was a lay side to it which was of vital importance, and in consequence he directed that in alternate years a scientific and a popular lecture should be given. He wrote that "there are not many natures predisposed to insanity but might be saved from it were they placed in their earliest days in exactly those circumstances and subjected to exactly that training most fitted to counteract that innate infirmity". No doubt this connotes much, and to some it may

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seem an overwhelming task. For it would appear to include a full appreciation of how mental disorder is brought about; what, if any, are the precursory indications; and what symptoms, when present, should be regarded as potentially dangerous to the future welfare of the mind of an individual. The inquiry is a fascinating one, and the problem can be more quickly unraveled by the working of physician, psychologist, and educationalist in close collaboration. Mental disorder unfortunately, as things are at present, becomes a medical matter only when it has advanced a considerable distance, but this must be changed, and it must be our endeavor as physicians to control its very beginning. Whilst it is right to devote time and energy to examining scientifically every means by which the recovery or the alleviation of mental disorder may be brought about and to use them to the full, in the end the return for these labors must be limited; to control its gateways and to prevent its occurrence far outrivals any treatment of disorder that has once become established. In fact, it is doubtful whether a complete recovery ever does take place in the sense that the patient is free from any scarring from the experience he has passed through. Preventive medicine is the side of medical science that is most attractive, offering as it does benefits of infinite value both to the individual and to the nation. Investigation tends more and more to establish the view that many disorders have their inception in childhood and experience confirms that this is true of the more common types of mental disturbance. It is on this account that I have decided to take as my subject for this lecture "Some Aspects of Education and Training in Relation to Mental Disorder". The term "education" will be used in its widest sense and will connote the instruction and upbringing of the child, both at home and in the school.

Controversy has always centered round the question whether mental disorder is in the main psychogenetic or physiocgenetic, and each theory has its able exponents. Experience has satisfied me that there is truth in both views and that it is unwise to disregard the potentialities of either of them. No doubt there is a mental instability in the majority of those who develop psychoneuroses or psychoses, but lowered physical health may be the final determining cause

of the breakdown, and I would go even further and suggest that in many of these cases, had the bodily health remained satisfactory, no serious nervous disturbance would have occurred. We cannot separate mental and physical processes, and it would seem unwise to attempt to do so when we appreciate how strong is the evidence of the interaction that takes place between them. Therefore, in the theme before us it will be necessary to consider the child as a whole and to give due heed to both its physical and its mental development. To regard it otherwise is to fall into the error too frequently encountered which not uncommonly results in faulty diagnosis. Further, let me predicate that the infant referred to in this thesis is the apparently normal, and not one who would suggest mental enfeeblement from birth.

It is not my intention to discuss the laws of inheritance, further than to remind my hearers that, though the child tends to inherit the attributes of its parents, fortunately this is nothing more than a tendency, and to be forewarned is to be forearmed—the knowledge of any weakness can and should be used for the benefit of the child. To ignore the possibility of any known weakness developing is to court disaster, whereas to appreciate it and to take steps to lessen its influence will in many instances repay the effort that has been expended. * Here

Our first step must be to consider if there are any mental factors whose presence is conducive to the development of mental disorder. As I am addressing an audience largely consisting of laymen, I must tell you that there are types of insanity which, like some physical diseases, are intrinsically part of the organism, and for which, with our present knowledge, little can be done either to prevent or to remedy. Fortunately these form by far the smaller group, whereas the larger includes the many that result from nerve exhaustion and emotional states. Therefore, it must be to the latter that attention should be first directed on account both of the number of cases and of the greater possibility of prophylactic measures.

Maudsley writes: "Insanities are not really so different from sanities that they need a new and special language to describe them, nor are they so separated from other nervous

disorders by lines of demarcation as to render it wise to distinguish every feature of them by a special technical nomenclature. The effect of such a procedure can hardly fail to be to make artificial distinctions where divisions exist not in nature, and thus to set up barriers to true observation and inference." It is these artificial barriers that have in the past so encumbered the way of progress. When one appreciates that in a given individual nothing more than exaggerated and uncontrolled normal characteristics may constitute mental disorder, we realize how narrow is the margin between those whom we call the sane and the insane.

Mental evolution should take place in a definite order and within certain recognized periods and any delay should be noted, but even more important is it to watch for any regressive symptoms which may indicate a failure or a dropping back to an earlier phase in the child's life history. Unless the observer has a keen perception, he will usually miss the beginning of any regression and in this way lose valuable time. Neither must he permit himself to fall into the common error of explaining away all mental changes as matters of no importance. Symptoms may be positive in the form of some new and unwonted mental characteristic, or they may be rather of the negative type, including conditions such as apathy, inattention, and the like; they are often protective in purpose, being an effort on the part of the organism to defend itself from any undue stress.

When one reviews a large number of patients who are suffering from nerve exhaustion in varying degrees, there is one symptom that appears early and that stands out in strong relief, and that is hypersensitivity. This state is observable, not only as a physical sign in the nervous system demonstrable by various tests, but it is a condition that also affects the mental processes. It is to me the symptom of all symptoms which gives rise to many others that in time may so disturb personality as to occasion definite unsoundness of mind. Here we have a symptom that is common to many children, but that in some, by its ever-widening embrace, slowly, but surely undermines the whole mental fabric. It leads to unhealthy emotion, to preoccupation, and to false reasoning; it heightens introspection, and by its presence it aggravates all the normal

characteristics of the individual; it disturbs the relationship of self to surroundings, and with this failure of adaptation a sense of inferiority or of irritation may result. It will be appreciated how baneful this hypersensitivity may become, and how by its intensity or by its duration it may injure the mental life of the individual. Nature has its own way of lessening the trying effects of heightened sensitivity, and the recording of acute sensation may suddenly cease and its place be taken by a psychical anæsthesia in which mind may become a blank or in some other way become disordered. Now if hypersensitivity can do all this, it behooves us to treat its advent with an appreciative recognition, and to bring all our knowledge to bear in an endeavor to defeat its progress. We must discover, if possible, how and why it arises, and then the conditions that favor its development, and lastly how it may be remedied or at least mitigated.

Some children are naturally hypersensitive, whereas with others the condition is acquired. Overstimulation is probably its most common cause in childhood, and this may be effected in many ways. Some children become overexcited by parties or by passing their days in unsuitable surroundings, and the harm that is being done may declare itself in irritability, querulousness, gastric upsets, or disturbed sleep. The naturally quick child is more liable to become overstimulated than the dull one, and its ease in learning delights both the parent and the teacher in instructing it. The early ability to read has an undoubted danger attached to it, for once it can do this the regulating of the time spent in the study of books can be carried out only with the coöperation of the child. During the early school days the danger of overstimulation increases, and the brilliant boy develops a new and legitimate ambition to outstrip his schoolfellows in knowledge. The result of this may be a scholarship, and from then onwards his course is fixed, and he must live up to his acquired standard, not infrequently without consideration of the injurious effect that close concentration is having upon his mental and physical health. Now it must be borne in mind that brain exhaustion is often of slow development and that it may not declare itself until school days are over, and the mental failure may be in varying degrees of severity. Some authori-

ties hold that the real blame for the competitive system largely rests with the universities, for these seats of learning are the goal for which the boy strives and for which the parent and the master prepare the way. I cannot do better than quote Dr. Herbert B. Gray, late Headmaster of Bradfield College, who writes in his book *The Public Schools and the Empire* the following weighty words: "Most physiologists would admit that the mere fact of such competition at such an early age involves a strain more or less harmful in after life. Apart from the unnatural stimulus of the mental powers, there is the excitement of the premature competition, which is opposed to all sound biological principles. Physiology contends that overstrain in mental effort hastens the period of adolescence, whereas the more highly organized the creature, the slower is he, or he ought to be, in coming to completed growth. Scientific investigations have in fact proved that the delicate mechanism of brain structure forbids such premature efforts of brain evolution. Inductive reasoning tells the same tale. The writer has been in close touch as boy and master with public schools for forty-five years. He is, therefore, familiar with many life histories, and is at least not 'entirely ignorant of the subject'. At some of the famous schools where scholarships are most valuable, and therefore most eagerly sought after, statistics go to show that winners of such prizes have in a large proportion of instances 'tailed off' either in the stage of early adolescence or soon afterwards. The brain in all these cases is proved to have produced premature results by early forcing. Some boys have shown no lasting power after two years of continued competition at their public school; others of less delicate brain organization or otherwise more bountifully nourished 'stay' till halfway through their university course; while others of still stouter mold do not begin to fail in power until they enter the competition of outer life; but only a comparatively small percentage fulfil the promise of their earlier years. The mental growth has become stunted and shriveled; the plant atrophies, and if it brings forth fruit, it brings forth no fruit to perfection in the maturer years. It is a wasted life." I have quoted Dr. Gray fully on this matter, as his evidence is of the greatest importance, coming as it does from a man of

long and wide school experience. Now what is true of the brilliant boy is true in a relative degree of others whose lessened physical stamina renders them more liable to overstimulation; defective circulation, respiratory disorders, and zymotic disease all accentuate the danger, and any one of these may be the determining factor in bringing about the collapse of an already overstrained nervous system. Further, if in addition to work the brilliant boy is also successful in games, his risks of breaking down are correspondingly increased. We are apt to forget that it is the same nervous system that serves both mind and body, and first to overstimulate it on one side and then on the other is to court disaster. I have known not a few child prodigies who have excelled in games and who have in consequence deteriorated mentally before the age of twenty. Physical fatigue may be damaging in several ways, but one of the most important is violent exercise occurring in a comparatively short space of time. I can recall the case of a young girl who developed an exhaustion delirium after running in a paper chase and who remained in a confused state for several months. I need hardly remind my hearers that such a delirium is almost certain to leave behind it a lowered nervous resistance for very many years. Children who are about to take part in any severe test of endurance should be inspected beforehand, and any who for either physical or other reasons are below their usual health standard should be debarred from the contest together with those who are constitutionally frail. The spirit of many a child far exceeds its power of physical endurance, and this high spirit may be raised even further by a powerful herd instinct which calls for an unusual effort for the good name of some school house or other school division. Further, apart from the actual physical strain, there are some forms of sport which in some young persons lead to an extreme bracing up of nervous tension. Any one may observe this in the trembling of the muscles of the young aspirant to athletic success; of course, this is in itself not harmful, but even beneficial when such effort is kept within limits, but overstimulation of the kind may be very damaging if by prolonged effort the nervous energies are overtaxed,

or if even a moderate strain is placed upon a physically or nervously reduced child.

Time will not permit me to make an exhaustive inquiry into the various circumstances that give rise to hypersensitivity, for the causes are numerous, including as they do physical diseases and disorders, defective sleep, and the overaction of various mind processes. On the other hand, its existence is easy of discernment, and its influence on the growing organism should not be overlooked. I am fully aware that there will be critics who will point to the mental hospitals that draw their patients from the country village and say that these cannot be the victims of overstimulation. But surely this is no answer, for the problem of mental disorder in the town is not necessarily that of the country and we find conditions in the rural districts that are rare in the urban. Intermarriage, with all its degenerating influences, is rife in villages compared with cities, and again a narrowed life has a deteriorating influence of its own.

Failure of power to concentrate attention is quite one of the earliest symptoms of overstimulation and exhaustion, and the symptom should be quickly discernible in the child. Attention is one of the attributes of normal mind which appears when the normal child reaches a certain age, and if it fails to develop, the faculty for acquiring knowledge is correspondingly diminished, the totally inattentive child being uneducable. On the other hand, if the capacity to attend has once been acquired, to lose it indicates a regression and its import must not be lost sight of. Nevertheless, the loss of power of concentration is of value as a means of protecting the nervous system from mental work that might be harmful to it. Unfortunately this symptom rarely secures the recognition it demands, and it is this failure to observe and understand that leads to the development of more serious disorder in later life.

Again, as overstimulation may in time give rise to inertness, it is necessary to refer to laziness. Owing to the untrained outlook of the lay mind, mental attitudes are apt to be classified in one category without any distinction as to how and why that attitude has come about. "A lazy child is a lazy child", and too often that ends the investigation, and this

verdict having been reached, the sentence is passed in due course. But laziness is a proper mental reaction to a definite debilitated state of mind, and to ignore it or to punish for it would be considered little removed from cruelty if the real circumstances were known. To appreciate the pathological significance of laziness, it is only necessary to read the term reports of a number of school children and to note how frequently we read that this child and that has shown indifference and inattention to his studies during the latter part of the term, and for this he comes in for condemnation. Yet in many cases the condemnation, if any is to be allotted, should be on the writer of this report for his lack of insight and knowledge of mind and its working. In support of my statement I will again quote Dr. Herbert Gray, who writes: "Every schoolmaster knows that the most productive work of the term is done during the first half of it, and that both masters and industrious boys 'tail off' in energy about the ninth week through sheer brain fag." That this is true there is ample evidence, but that it should be permitted to continue is less easy to understand. It cannot be argued that "brain fag" is a benign state even in the adult, but to produce it in the plastic nervous system of the growing child is little short of culpable, and to prevent it must lessen the incidence of nervous and mental disturbances. When laziness is to be observed, search for any legitimate causes that may be giving rise to it, and only find fault or punish when these have been eliminated. It is, unfortunately, more common to condemn first, and only when correction has failed to produce the desired results, to investigate in other directions. To follow such a course not only increases the mental damage to the child, but it injures personality by establishing a sense of inferiority in the good and a callous indifference in the bad.

As defective sleep is a common cause of the development of hypersensitivity, it will be well to consider it before we leave this subject. All living organisms require proper time for repose, and it is safer to permit of a longer rather than a shorter one, especially during the early and growing years of childhood. The child should be trained to sleep during the day if possible until it reaches the age of five, and to neglect this part of the training not infrequently permits of too

rapid development which brings with it restlessness and overstimulation. Children up to the age of sixteen should have at least ten hours' sleep, and from sixteen to twenty, nine hours should be allotted for rest. When considering sleep, it is necessary to give weight to the quality as well as the quantity. A restless sleep, full of dreams and broken by nightmares, is unrefreshing and indicates an unsatisfactory condition of health, and the child who persistently exhibits such symptoms is not in a fit state for the ordinary work of school. The nervously overstimulated child fails to sleep, and when this happens, it indicates that the organic side of life is being disturbed, and this will shortly declare itself in loss of body weight and other symptoms if steps are not taken to correct it. Again, sleep is rhythmic, and it can easily be broken by interrupting the rhythmic habit by evening dances, theaters, and the like. There is little doubt that some parents permit of serious damage to their children by giving them this type of pleasure. Broken sleep is not easily reestablished, and even at best, once it has been disturbed in this way, it is easy to relapse into a sleepless state again. Evening school preparation work has always seemed to me to be of doubtful value, and it is definitely harmful to some children. The work before retiring to bed should be of the lightest, and probably in time we shall see with advantage the hours after tea being devoted to light lectures or instructive games. Some schools are open to criticism for the way that the younger boys are disturbed by the older ones as they go to bed at a later hour. The nervous apparatus for hearing must always be active and alert, as it is largely on this special sense that the sleeping person relies for warning of impending danger. If you doubt this, watch the restless movements that are produced in a sleeping infant by sudden sounds, and these movements are the translation of sensation into action. Some children are definitely awakened, others merely disturbed, by sound, but practically all must be affected by it. Further, sudden noises not only awaken, but startle some persons—this is known to all anæsthetists—and the disturbance created may not quickly subside. Therefore, this matter is of practical importance and cannot be brushed aside as a frivolous observation. For a time some children, like some

adults, do not appear to suffer from defective or deficient sleep, but because there is no gross objective sign it does not necessarily follow that deterioration is not taking place, and experience teaches that it is the wiser course to treat the condition seriously rather than to venture a hazard that all will be well. Broken sleep of short standing can easily be remedied, but if once established, it is a far more difficult proposition.

I will now proceed to consider emotion. We owe to Déjerine a debt of gratitude for the emphasis he has laid on this attribute of mind and how it may affect the mental health. Every one knows how devastating is passion and how exhausted it leaves the subject who has been enduring it. But emotion exists in varying degrees, and although in its more severe forms its physical concomitants of pallor, flushing, tears, tremors, and the like are in evidence, some of the more subtle types are less easy of discernment owing to the apparent absence of somatic signs, and yet they may be working steady and untold havoc. Emotion becomes attached to ideas and groups of ideas, and if the emotion is an unhappy or unpleasant one, it very readily leads to a "preoccupation" which may slowly absorb attention until it seems to fill the whole field of thought. "Dreads" and "fears" belong to this order and these are not uncommon in childhood. Many fears are unreasonable, but this does not lessen their power, and the inability to drive them away is both depressing and terrifying to the sufferer. He must be helped by a sympathetic and philosophic understanding. Unless relieved, a fear of this kind may affect the sleep and produce bodily disturbances and lessen mental activities by setting up a hyperattention on one subject, instead of the normal state of being able to turn the attention in any direction. Now emotion of this or a similar kind may result in the development of a sense of inferiority—a feeling of being unlike others. When this takes place, introspection begins to play an important part. The healthy mind is largely extroverted; thoughts are projected outwards, but in certain morbid emotional states the process is reversed and everything is turned inwards. This leads to unhealthy reasoning; it interferes with the relationship of the child to others and not infre-

quently results in a solitary existence. The child who has formerly been fond of companionship and who in course of time becomes lonesome is usually evolving into an abnormal mental state, and every effort should be made to clear away the difficulties. Unless this can be done, the morbid outlook, which at first is scarcely discernible, becomes, over extended time, a factor of such importance that life is almost unbearable. For this feeling of inferiority gives rise to suspicions, ideas of persecution, and resentment, any of which are factors of no mean importance in the mental make-up of an individual. Some children develop this sense of inferiority from being laughed at by their schoolfellows. I do not wish to convey that "chaffing" is not in the main a healthy mental exercise, but it may stultify, if not worse, the intellectual growth of some children, and it is these whom we ought to save if we observe as we should do. I have heard a well-known training officer in the army say that a man who was "gun shy" and who was clumsy at games has ultimately excelled in shooting and in sport by steady encouragement, whereas experience has shown that were this not given him and were he allowed to be unduly chaffed, he would drift, as many have drifted, into a solitary, useless person, full of grievances. Remember that mind is never stationary and in the course of evolution factors that are of small moment to-day may in time become of absorbing importance. Maudsley recognized this, for in speaking of extreme shyness which is the unfortunate disqualification of some nervous temperaments, he writes: "Only those who have it can know how sore an affliction it is and how great a let and hindrance to them through life. Nay, it sometimes wrecks a life. For as the unamiable proclivity of mankind, as of other animals, is to set upon and persecute any individual of the species which differs from the conventional type, it happens that when a nervously sensitive and shy boy is sent to school, he is teased and bullied there because he is not like other boys. If he meets with no one to understand him, to show him sympathy and kindness, he gets more and more estranged from his fellows, more and more he feels himself a peculiar and separate being, suffers, mopes, and pines in solitude, and in the end is so shattered mentally, perhaps, as never in after life

to get over the injury which has been done to him." Those who have children in their keeping and who believe that boys are best left to themselves to find their own places among their fellows, to statements such as I have just read make answer, "Yes, we know all this, but the few must suffer for the good of the majority." My reply must be, "Is this necessary?" The educationalist does not keep back the brilliant child; he bestows upon him his special attention for reasons that are obvious. My experience goes to show that the rewards will be as great for a more careful study of other types.

Repression is a mechanism that has attracted increasing attention with the advent of what is commonly spoken of as the new psychology. Freud laid down that forgetting is not necessarily a negative process, but a positive one, and that experiences of an unpleasant character do not fade away with time, but are definitely repressed out of consciousness. This is probably only partially true; some natures undoubtedly have to treat unpleasant experiences in this way, but many do not do so. Freud realized that there must always be a danger of a conflict taking place between the primitive instincts and the demands of the community, and further that a termination of such a conflict may only be possible by the active repression of the former, which usually entails emotion and is in consequence fraught with danger. If the individual is successful in fully repressing the unpleasant experience, it passes out of the realm of consciousness; nevertheless Freud has shown that it may remain as a dissociated portion of the mind, with the potentiality of becoming active under certain conditions on account of the original emotion attached to it. According to Freud and others, its harmful effect is in the amnesia (loss of memory) occasioned by it. Wingfield, in his book on hypnotism, lays special stress upon the preceding emotional state of a repressed painful experience. He gives instances in support of his view that the emotion always precedes the rising of the repressed thought into consciousness, and thus the emotion leads to an automatic shutting out of the incident until in time it is entirely forgotten, the emotion alone remaining. On the other hand, there is no doubt that many so-called repressions are not

fully repressed, but remain more in the realm of consciousness than some authorities would suggest, but nevertheless they have a very wearing effect upon the nervous system and in the course of time begin to have a deleterious effect upon the mind of the individual. Repression takes place during all ages, but the struggle with authority is more common during certain periods of childhood and the damaging effect of a conflict is more serious upon the growing, plastic brain of the young. That Freud was wrong in believing that most of these repressed complexes were sexual in character is becoming increasingly evident, and I have long felt that when this is dropped as an intrinsic part of the Freudian theory, the latter will greatly benefit. To me Freud's teaching is valuable, not in its methods of psychoanalytical treatment, but because it emphasizes an important factor that had been overlooked—how conflict, with subsequent repression, may injure the mind. The knowledge of this alone must make parents and educationalists pause for reflection and to examine whether their attitude toward the young in their charge is in accordance with it. It is not my intention to convey that all repression is harmful, for indeed repression is a normal mental process, but like the "will", some persons try to use it for unsuitable purposes. Repressions that are harmful usually tend to center round some morbid thought or some particularly disturbing experience. It is the psychological atmosphere in which the child develops that leaves its mark upon its future life, and therefore its later welfare is dependent upon those conflicts, repressions, and any other mental conditions that lead to unrest being especially guarded against. If this were fully known and appreciated, I believe that greater consideration would be given to the conduct of the home. Children, and especially the sensitive ones, are far more perceptive than many adults give credit to; they note the gesture, the conduct, and the language of those about them and they rationalize in an elemental way, but it is none the less leaving its impress on their evolving minds. Further, it is all-important to bear in remembrance that it is not the subjects which are freely talked about by the child that are usually harmful, but those upon which he introspects in silence. To the observant person gesture lan-

guage will convey as much, if not more, than words, and no one can claim to be an efficient trainer of children unless he is equipped with the faculty of reading it. Words may be misleading, but gesture is seldom so, for the latter is complex and is the outward and visible sign of inward sensation and emotion. As Maudsley once wrote: "What is mind-reading, but muscle-reading through movements so fine as to be discernible only by a practised sensibility?" Every adult knows the effect exercised by the environment of an unrestful house, and its influence upon a child must be infinitely greater. And when to unrest there is added apprehension or definite fear, it does not call for a great effort of the imagination to appreciate the damage that is being done. The undisciplined man is a burden to himself and a thorn in the side of his fellows, but the child who has to live with him is in danger of mental ruin. This may appear to be forcible language, but thirty years of experience of nerve work forbids me to soften it. The greatest hope for the lessening of the incidence of mental disorder lies in a fuller awakening to the duties of the parent to the child. There is one thing that the state can never effectually perform and that is the office of parent, and those who wish that it should do so either have a very small insight into what is really meant by parental care, or they must feel that the thoughtfulness of the average parent is such that the child is safer out of his keeping. Had we but the vision to see, there is no reason why either of these views should remain active, but to escape from them there is only one way, and that is to increase the sense of responsibility of the parents and not to lessen it; otherwise the natural consequences must follow. Those who call for larger families without seeing that the parents who have them appreciate their duties are incurring a grave responsibility. The stability and happiness of the mass are the combined effect of these virtues in the individual, and it is to parental care that we must look to lay their foundations.

The child who is naturally repressed is without doubt more difficult to train than the one whose temperament is open and frank. It is less easy to understand and is usually more resentful of interference, and for this latter reason punishment not infrequently does more harm than good unless it is

carried out with great circumspection. On the other hand, such a child may develop into a fine character if training has been judicious, for it is often capable of much reasoning power and its intelligence may be above its years. When and in what way to punish the child become problems of increasing perplexity as more is known of the working of mind. The crude rule-of-thumb methods of the past must be more and more challenged. We now know that in apparently correcting a fault we may damage the mental development of the child unless we keep this actively in mind when meting out the sentence. Take, for example, the matter of corporal punishment. In referring to this I do not wish to be misunderstood; I am not one of those who believe that all punishment is wrong, for whilst human nature is what it is, punishment in some form or other will be necessary. My criticism is that it is too often administered according to tradition and custom rather than by the exercise of a wise judgment. For example, it is difficult to understand how caning and corporal punishment are so commonly left in the hands of prefects, whose knowledge of mind development must be nonexistent, and this being the case, it is the crime that is punished and not the author of it, and the effect that it may have upon the latter is left on the lap of the gods. I have known of a young boy caned by prefects several times in his first term for minor offenses until finally he ran away in a high state of nervous excitement, and this at one of our best public schools. Such treatment may claim to make some boys into fine men, but undoubtedly it also causes some to become nervous wrecks, and I cannot help feeling that it ought not to surpass the wit of man to evolve some scheme of punishment that would have all the benefits of the present system and less of the disadvantages. Government by prefects has, when properly carried out, a highly beneficial effect upon a school, but duties should not be imposed upon them which are clearly beyond their powers of full appreciation. Dr. Herbert Gray, in writing on corporal punishment, says that he has "no hesitation in maintaining that it should be confined, when administered at all, to offenses of a moral or quasi-moral character, such as lying, cheating, evil language, and misconduct of a similar type". Now that it is known how damaging

is emotional shock to some individuals—and this must be more likely to occur in a child—it behooves those in authority to resurvey the grounds for and the methods of administration of corporal punishment from the psychological standpoint. I am not aware to what extent the writing of "lines" is still practiced in schools, but it is a form of punishment to which there are serious objections. To write out hundreds of "lines" is to fatigue the hand center, in addition to other parts of the nervous system, and when it is imposed for "inattention", which may be due to brain fag, the result is obvious. Speed alone in a mental exercise is exceptionally fatiguing, and what boy does not write his "lines" with the greatest dispatch at his command, and what master does not know this, for does he not intend to keep the boy at it for a definite time, and to do this must he not be guided by possible pace rather than by slowness? I know that many school authorities are taking a more scientific outlook in the treatment of delinquents, but much has yet to be done, for traditions die hard, and it is apt to be said that "what was good enough for us is good enough for the boys of to-day".

There is another type of child to which I might refer, not because of the frequency with which it is met, but rather on account of the very damaging effect it usually has upon its fellows. Fearlessness is an attribute that rightly holds a high place in character, but like all virtues, it may lose its value unless it is tempered by judgment. To train a child to be fearless unless at the same time it is acquiring experience is to court very definite danger. The fearless child becomes independent above its years, and with independence it may develop a dictatorial and bullying spirit. Many of these children, when puberty is over, pay less and less heed to authority and become quite insensible to kindness or severity, and not a few fall into the hands of the police for breaking the law. This all goes to prove that mind development should be a homogeneous whole, and although interest and aptitude may tend to quicken growth in certain directions, these tendencies must be watched and kept within reasonable limits.

During recent years much has been written regarding phantasy—not that it was a fresh discovery, but on account of its place in the new psychology. Now make-believe is a

normal characteristic in all young children, but some have it much more fully developed than others, and these are usually the sensitive type. As with reality, there are two large classes of phantasy: the one includes all that stands for brightness and happiness and the other all that is ugly and forbidding. That the latter should play so formidable a part in the child's story and picture book has always been an enigma to me; for to the sensitive child it may do much harm and its power for good must be very small. Nevertheless, phantasy is good, as it smooths the path of the child on its way to the stern realities of life. Whatever its troubles, it can soon forget them in the land of fairies. But as years pass, it is necessary for phantasy to be slowly replaced by realities, and it is incumbent upon the teacher to prepare the way for this transition. Realities must not be made too hard, otherwise the child is driven back into phantasy, or in silence it may fret until the rising emotion shows itself in varied forms of nervous disturbance, or if it is made of tougher material, it may slowly harden into an attitude of careless indifference or open rebellion. One child easily slides over the difficulties that mark the opening years of its life, whereas another requires help, and it is urgent that this help should be given. What I have already described as a wise, philosophic, yet sympathetic understanding is what is called for, and not the enervating, "sloppy" sympathy which is apt to be given, interspersed from time to time with an undisciplined display of irritability.

Although phantasy is a marked feature of the mind during early childhood, it may persist or reappear in the later school days. If so, it will call for inquiry as to why it is there. The adult has his day-dreams, but they ought merely to be an outgrowth of reality—a visualizing of some ambition that is as yet far off, but the contemplation of which affords encouragement in the present and a vision of hope for the future. On the other hand, phantasy that has no normal relationship to life indicates that an older child has either regressed or that his mind is not developing normally. At this point I may be met by those who believe that "self-expression", in whatever form it may take, is the factor of overwhelming importance throughout a child's life, and that what some may regard as phantasy is nothing more than the unfolding of a creative

mind, which may easily be stunted by careless handling or failure to appreciate the condition in its true light. I agree, as I suppose most would agree, that self-expression has been sadly neglected in the past and that schools have been conducted to meet the requirements of a standardized child which, to avoid any difficulties in differentiation, has been termed the normal child. Those whose mentality did not permit of their fitting into this charmed circle either risked becoming chronic failures, or, having weathered the contempt to which they may have been exposed in early life, have developed, when once freed from the system, into successful men in whatever sphere of work they may have taken up. But because "self-expression" has been a neglected factor in the past, there is no reason why it should be granted too free a place in the education of the future. Sooner or later the instinctive impulses of the child must meet and, if untrained and unconditioned, must clash with the social régime; he is unable to free himself from the herd. What he thinks of others and what they think of him are musings which, if allowed to run riot, may entail his downfall, but if rightly directed, may lead to the development of a character where self is almost lost in interest for others. It is this adjusting to the demands of the herd that is often so difficult, and when one appreciates what it means, the adaptation of an ever-changing being to an equally kaleidoscopic world, it is remarkable that misfits are not more common. But apart from actual misfits, we are still far behind in what could be done to make the best of life and to equip the young for the work that they have to do. The normal child is extroverted, and if introversion is noted, every care must be taken to develop its ease of expression. It is frequently the sensitive child who is introverted, and he may otherwise be one who is endowed above the usual with powers of perception, and, given suitable care and training, is often capable of fine development. If, on the other hand, by any misfortune he finds himself under the care of unimaginative and commonplace persons, his life will become increasingly cramped by the conflicts within and the cruel pressure from without. Nothing is more tragic than to see the introverted child suffering mental anguish more exquisite than physical pain, and in consequence closing the way to mental develop-

ment, and in many cases all because it is not understood. But a child may be too extroverted, and in this case also its mental future is in jeopardy, but in a different way. Its danger is in the limelight, and in an undue appraisal of its ability. If its fiber is tough, it may at first trample its way through or over the herd until it ultimately breaks down, a victim of its own conceit. Nevertheless, if the dangers of such a child are appreciated early enough and if it is handled with judgment, it will be found in many ways one who is more easily led than the introverted one; but time is against the teacher, and once puberty is reached, the task becomes infinitely more difficult.

As childhood advances, all the natural instinctive impulses must become conditioned, and by this we mean that experience must modify them. Impulse is an unconditioned reflex, whereas a volitional act is an action that has been toned by experience to the environment in which we live. The instinctive impulse of a man who is exposed to danger is to run away, but training and experience teach the soldier that this is contrary to the opinion of the herd, and in consequence the fundamental law of self-preservation is conditioned and annulled by the dictates of the social order. Untruthfulness and other moral delinquencies belong to this category, but just as many men who ultimately turn out to be trustworthy soldiers cannot be trained by any intensive system, similarly certain children require long and careful handling. By harshness the normal sensitive child may become confirmed in its lying, for falsehood is a defense of the fearful, and once it is consciously established, it becomes an active detrimental factor in its future mental welfare.

In this way we reach what is and ever must be the goal of all mind training—self-discipline. By this I do not mean a mere clicking of heels to authority, right as this may be in its proper place, but true discipline, connoting the right proportional working of all the attributes of mind in an even way. The undisciplined nervous system is one that reacts impulsively and violently on slight provocation. Persons who are undisciplined and querulous not infrequently vent their displeasure in spiteful acts; they are highly unreliable, and yet they may be possessed of a personal charm that throws their

defects into singular relief. There is no unhappier state than that of instability when a man finds himself reacting abnormally to thought and environment. Ultimately he finds that there is no place for him in the world, and rationalize as he may that his so-called undisciplined outlook is a proper reaction to an unfriendly community, his own uncontrolled language and actions alienate him from the herd. Many of these individuals end their days in mental hospitals, their nervous system having finally broken down under the strain of contending with men and things, and yet, when carefully analyzed from the psychological standpoint, there can be discovered no intrinsic reason why such a state of mental unsoundness should have been brought about, had reasonable care and supervision directed the earlier years of their life. All children are undisciplined, and though the majority acquire controls by the education and training that they receive, some lag behind in gaining them. The child that does not become disciplined at the usual age is often quite intelligent and may even attain to a high standard of knowledge, but when a child shows defects in the matter of control, it is necessary to focus the immediate training upon these defects, for knowledge is useless to the possessor of an unbalanced mind; far wiser is it first to obtain stability and then to impart knowledge. The irritable child, like the irritable man, must not be regarded as in good mental health, but the brain of an adult takes longer to damage, and although it is true that each outburst of irritability is gradually undermining the mental power of the man, its effect upon the plastic, growing brain of the child is vastly more injurious. Further, the child forms habits with extraordinary ease, and once established, they are infinitely difficult to displace. Discipline is not a product of short training, for it is not elemental; its component parts are highly complex, and in consequence its development is slow and subtle, but once established, its reward is stability, and it protects its possessor from the effects of undue strain of conflicts within and irritation from without. As we acquire knowledge, thoughts and acts that at first were accompanied by a feeling of effort grow to be automatic. Right thoughts should become associated with proper actions. Sound experience means that we instinctively

do the right thing at the right moment; the adult mind should be stored with judgments that have been tested by experience and can be called up more or less automatically when occasion requires it. It is not the knowledge that we have acquired that counts so much as with what other things this knowledge is associated. The knowledge of finance associated with extravagant or penurious thoughts is of ill value; cleverness and much learning when associated with conceit are singularly unattractive; business capacity when associated with an intolerance for others often is a valueless possession. When we come to test a man's endurance or what he has made of his life, it is rarely pure learning, it is knowledge added to something else that gives it its value, and it is this "something else" that either makes or mars the history of that life. It is outside the purpose of this lecture to discuss all that goes to make character, but just as the good morale of troops keeps an army in a high state of efficiency, so with the individual it is the fundamentals that count.

It is remarkable what apparently insignificant factors may so increase the burdens of life that, starting as a small nucleus, they may form a center which in course of years may collect round it other factors until the cumulative effect is greatly to disturb the mental equilibrium of the individual. What for want of a better term may be called "sloppy-mindedness" is an example of this. Some parents give so little heed to the future welfare of their offspring that they bring them up indifferent to principles and untidy in thought and action. The innate intelligence of the child may permit of its acquiring knowledge maybe above its fellows, and when it starts on its life work, all goes well until responsibilities have to be accepted. It is then that the "sloppy-minded" training begins to tell, for it may and often does so handicap the man's progress that troubles which might easily have been prevented overtake him, and these and the unhappiness that is associated with them become so disturbing as to render him a mentally broken and disappointed man. There is another group of cases that are particularly sad, as they often involve the break-up of a life that from the earliest of days has been devoted to close application to work; this group includes those who have arisen from the ranks and who,

through scholarship or unceasing study, have acquired some good position, only to find that their personality is unsuited for the post. The issues of life cannot and must not be lightly faced; phrases like "equal opportunities for all" have a fascinating sound to the uncritical mind, but if you carry this assumed truth into general practice, your kindly attention will bring about the mental downfall of many of those whom you intended to help. The tendency of the age is to standardize everything, but when this system is carried into the management of human affairs, the results cannot but be disastrous. Although it may be true that men whose mental capacity is nearly equal can be arranged in groups, and although, further, it is true that a certain number may be capable of being transferred from lower to much higher grades, the majority must be content to move within narrow limits. Evolution is at all times slow, and to attempt to hasten it is not only unwise, but disappointing. The natural laws plow on with an unmerciful regularity, forever heedless of the ever-changing fashions in the opinions of men. It is proper to see that the want neither of money nor of position should stand in the way of the advancement of those whose natural gifts permit of this, but to regard it as the normal right of the majority is to think a vain thing. I know that my critics will say that this is precisely the difficulty—to know who has natural gifts and how such can be gauged. To these my reply must be that this is the duty of the educationalist, for he must search until he finds some reliable test that will decide this problem, but to attempt what some would have us do—give all a standard chance—is too wasteful in practice and too hurtful to those who fail. The problem is full of perplexities, and no doubt there are many who are striving to find the right solution, but unfortunately the claimants who demand to be heard are many, and each regards the proposition with a distinct bias of his own. There is first the parent who sees in his offspring qualities that, if given opportunity, are pregnant with possibilities; and next the schoolmaster, kindly and hopeful, fully aware of the limitations of his pupil, but always ready to give him the benefit of any doubt. Next in order comes the array of examiners and school inspectors, men whose outlook is largely concerned

with a standard of knowledge, the human element entering into the scheme only as a means of expressing that knowledge. Next come the universities and great seats of learning, whose duty it is to indicate the educational needs of men and to hold out as their highest aim, irrespective of individual characteristics, the attainment of pure scholarship. Finally we come to the legislature, the mouthpiece of popular opinion, who are willing to fling education into the maelstrom of political notions, careless of the effect so long as it appeals to the masses and in consequence strengthens some party at the polls. If only each claimant would wholeheartedly view the proposition from the standpoint of the child and his future welfare and put away from his mind all other considerations, the problem should be capable of a right solution.

Psychological medicine has been progressing rapidly during recent years, and with this one of the most satisfactory features is that the word "mental" is being used more and more freely with reference to normal individuals. At one time any reference to a mental state had a terrifying effect upon the lay mind, and it is all to the good to find that the public is learning that mental processes are common to the normal as well as to the abnormal. We now await the time when the legislature will show its appreciation of the advance that has been made by relaxing the law so that the knowledge that has been acquired may be the more readily used for the benefit of the people. In the meantime we must go on teaching that the mental health of the nation is largely dependent upon a widespread knowledge of the requirements for keeping a mind in health. The position is in every way comparable to the problem of attaining a high standard of physical fitness. The onus must ultimately rest with the people; the medical profession can but point the way. If the present writing on the wall is correct—that the early years of life are the important years for determining the stability of the mind of the adult—it behooves us to put this knowledge into practice. The country is learning that the greatest asset of a nation is good health and that a small number of A1 men count for infinitely more than a crowd of the C3 class. To attain this end we must look to education, not merely from the narrower standpoint of learning, but where learning is super-

imposed upon a stable mind. I would close, as I began, on a note of hopefulness. The criticism that is often made against prophylactic measures is that it is pure hypothesis to say that such and such a condition might have arisen, and that the claims of having prevented it are in consequence mere assumption. We at least shall be free from such uncertainty, for we shall be able to point to fewer and less populated mental hospitals. We know that this result can be attained, even with our present knowledge, and all we ask is that those restrictions which hinder us should be removed, and that the lay public should bear in mind that mental disorder is rarely of sudden development and that much more can be done to prevent it than they at present appreciate. For ourselves, we who work in the sphere of mental medicine must keep widening and ever widening our vision as our knowledge advances. In our struggle to repair disease, we must not lose sight of the other matters that belong to our inheritance, for our work has no narrow scope, covering, as it does, all that appertains to the mind of man.

THE MENTAL TESTS OF A SUPERIOR CHILD

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USUALLY, if a teacher believes that a child is mentally incapable of doing the work of her grade, she asks for a "Binet". When she receives a report that the child is 60 per cent *below* normal in intelligence, she says slowly and emphatically, "I thought so", and confidently takes measures to have him transferred to a class whose work is better adapted to his stunted intelligence. But suppose there is another child whom the teacher considers "bright enough", but who is doing rather poor work. Later she receives his Binet score, which shows an intelligence of 60 per cent *above* normal. Instantly she is up in arms. "I can't believe it", she argues. "I've taught twenty-one years and I ought to know. Why, he can't even get high marks in *this* grade!"

The above paragraph introduces a popular theme—namely, the dissatisfaction experienced by school authorities when their professional judgment comes into conflict with psychological tests. The following is a short, true story illustrating that theme.

The story is about Tom,¹ eight years of age and in the third grade, A section, of one of the Twin City schools in the year 1921. In this grade he was specializing in the formation of three habits: namely (1) obtaining low marks, (2) disliking school, and (3) "feeling sick" in the morning with recovery about noon.

Tom's mother, before marriage to a professional man of ability, had been a teacher in the elementary grades. She had subsequently taken advanced work in mental measurements and had kept pace with the newer trends in elementary education. In view of these experiences, she had always felt sure that Tom, the oldest of five children, was above the

¹ Fictitious name.

average mentally, though how much she could not say. She suggested to the school authorities, therefore, that Tom receive extra promotion, but was advised that nothing could be done until he had had a mental test.

The crucial day arrived. Tom was sent over to a school where mental tests were being given in the third grade. He took the Haggerty Delta 1, a group intelligence test for the grades from one to three, and scored 64 points, 6 points *below* the norm set for third-graders. He was classified as "slightly below normal". Tom's mother was literally dumbfounded. What kind of a "mental test" had the boy taken! So she went to the psychological examiner who had given the test and suggested that he give an individual examination to check results. He was very busy and referred her to the university psycho-educational clinic.

The examiner at the university clinic gave the Stanford-Binet examination, brief scale, and found, in contrast to Tom's chronological age of eight years and seven months, a mental age of 15 years, 9 months, with an intelligence quotient of 183—one of the three highest quotients obtained at the clinic during a period of four years. No wonder that Tom was forming undesirable habits in the third grade! He had the mental development of a high-school boy, and what high-school boy would deign to exert himself if confronted with the "baby work" of a third grade?

To put it in terms of the Binet test, could Tom, with his superior capacity, be expected to adjust himself to third-grade work when he was able to respond correctly to the induction test in Year XIV, or to explain easily the "lessons the fables teach" in Year XVI? It is a question whether the teacher of the grade could do better than Tom in recalling the passage in Year XVIII. Tom's reply was:

"Many opinions have been given on value of life. Some are good and some are bad. The correct thing would say it was med. . . . For our happiness is never as great as we should like and our misfortunes are never as great as our enemies would like them. So it is this med. . . . which keeps things from being unjust." (He explained correctly the meaning of the word "mediocrity", but he could not say it.)

Tom also did the second and third ingenuity problems in Year XVIII after the first had been explained to him.

Furthermore, Tom had a cheerful smile. He carried him-

self erect and showed to advantage a fine physical build. He admitted frankly that he intended to be a "prize fighter" and to this end was developing "hard muscle" by systematic exercises and special stunts on a pole planted in his back yard. "I can 'chin' seven times", he confided. The mother confirmed this and added that he was reading Mark Twain, although she wondered—oh, subtle inquiry!—how he could understand and enjoy this author and yet not do good work in the third-grade reader.

Joyfully the result of Tom's Binet was communicated to the school psychologist. In response came the chilling comment that Tom must have been coached by his mother. Personally the university examiner was willing to take oath that, irrespective of any possible coaching, Tom was by nature a superior child. But he recalled Tom for further examination.

At the second visit to the clinic, Tom's mother frankly explained to the examiner that she had been told that she had coached Tom in the Binet, but that this was not true since, in the first place she had never worked with the Stanford-Binet, and in the second place she was aware that should she coach him, he might temporarily be advanced, only sooner or later to be set back in disgrace.

At the second clinic session, for purposes of comparison, the Haggerty Delta 2 was given. This is a group intelligence examination for the grades from three to nine and consequently much more difficult than the Delta 1 for grades from one to three, in which Tom had scored slightly *below the norm*. In the Delta 2 he scored 91 points, 4 points *above the age norm for the representative thirteen-year-old child*. The Haggerty sixth-grade mental-ability norm comprises 96 points; hence Tom might well have been working in the sixth grade.

Explanation of the causes of this discrepancy between the two test results is difficult. It may lie, however, in the fact that in the Delta 1 two of the tests have to do with *similarities* and *differences*. For instance, in Exercise 12 there are twenty-five pairs of words with the instructions: "If the two words mean the same, put an S between them. If they mean as different as can be, put a D between them." The mother commented that her son had been trained to differentiate

clearly between words and that his appreciation of shades of meanings was exceptional, the child sometimes correcting his parents in their use of words. So when the examination called for an S or a D for "sad . . . sorry", he put a D, since to him the condition of being *sad* was quite different from that of being *sorry*. In the same way he marked "climb . . . ascend" with a D instead of with the correct letter S. In fact, examination of the test blank showed that Tom had actually achieved exceptionally low scores on these particular tests. Whatever the explanation, however, the results of the Delta 1 and the Delta 2 are truly interesting because they show that a primary test may fail to measure properly a "primary" child of exceptionally superior intelligence and training.

The second test given was the Army Performance Test, brief scale, standardized for adults. Obviously this was not a fair test for a boy of eight, but the examiner was interested to see what he would do with this kind of material. Tom made a total of 179.3 points, equivalent to a mental age of 12 years and 6 months. He did the ship puzzle perfectly in 38 seconds, the feature-profile perfectly in 67 seconds, the maze tests with a total of 22 points raw score (total possible raw score being 32 points), and 7 series in the cube imitation. His achievements in the triangle and diagonal tests in the Pintner-Paterson series were 100 per cent correct and done in 45 seconds and 20 seconds respectively.

The next move was to send a report of the three intelligence tests given at the university clinic to the principal of the school that Tom attended. In this communication the examiner used his best technique, being aware from experience of the touchiness of some principals in regard to "outside interference". It was suggested in the letter that Tom be allowed to try the fifth grade.

No answer to this two-page letter was ever received. The mother waited a week for the expected telephone call from the principal, then visited the school to make inquiries. At the school she was told by the principal, "We are not taking orders from the University of Minnesota." Tom's mother then inquired whether Tom was considered intelligent in school. The answer was, Yes, in literature, in which he can

have coaching at home; in arithmetic he is poor! In short, nothing could be done. Not even authorities "higher up" would yield an inch. Tom would stay in the third grade, "where he belongs". The situation paralleled a stone wall—solid, hard, unresponsive, cold.

Frankly speaking, is this a unique situation? Should we not hear more about the *failure of school officials* to coöperate with children and parents? We hear enough about parents who do not "coöperate" with school authorities or who are irrational in their criticism of the school. And how about the resultant effect upon the "morale" and "mental health" of the child and his parents?

Tom's mother made a final effort. She decided to put Tom in another school, where individual mental tests were given and their results sanely interpreted and acted upon. Previous to her petition for this transfer, however, Tom was taken to the school and given the Kuhlmann intelligence examination by another university examiner. In this test he obtained a mental age of 11 years, 7½ months, and an intelligence quotient of 133. The discrepancy of fifty points between the Stanford-Binet and the Kuhlmann test, even taking into account that the former was the brief scale, is difficult to explain. Irrespective of this difference, however, on the basis of the Kuhlmann test, the examiner commented that Tom was *superior* and might well skip to the fifth or sixth grade.

Reinforced by this *fourth* bit of evidence regarding the general "mental level" of her child, the mother went again to high authority and demanded that something be done. Finally, after due deliberation, she was told that at the end of the quarter Tom might enter 5B in the school he was attending. "But why wait until the end of the quarter?" the parent argued. And so it happened that Tom entered 5B the very next day.

The story continues as any one who understands the "superior" child could have predicted in the beginning. Although Tom had entered the fifth grade just before the end of the quarter, he took the "finals" and did very well in all subjects except geography, where content played an important part. In arithmetic he made 100 per cent. Later he passed on to 5A and continued to do fine work. Tom's report

at the end of the first six weeks was composed for the most part of "very good". Only two subjects were "fair" and there was nothing below that. The mother reported that his attitude towards and interest in school work were both much improved, that he received much better marks than he had in the third grade, that he was almost at the head of his class, and that he had made the class baseball team. A later report in the fall of 1922 noted creditable work in 6B, Tom's last report having "good" and "very good" in all subjects but arithmetic, in which he got "fair". The teacher commented that he understood the work in arithmetic, but was slow in finishing in a definite period of time the routine work allotted to the class. (This inferiority in routine work suggests Doctor Whipple's statement that the "superior child" is usually a radical and systematic objector to routine class work.) In fact, if arrangement could be made for a group of the brighter pupils in 6B to skip 6A and enter the seventh grade direct, Tom would be among the number, provided he brought up his arithmetic. Furthermore, Tom now "chins" twenty times.

In view of this story, are we to believe that the "understanding of the child" by school officials, about which we hear so much, reduces itself in a large majority of cases to an "official" opinion of the child based on few or no facts? Further, are we to assume that educators believe that a mental examiner of recognized standing actually would take time to make practical recommendations about a child if his evidence consisted solely of an "M. A." and an "I. Q." based on a routine "Binet"? It is ludicrous. The psychological examiner, as well as the educator, needs a background of physical and mental facts and a knowledge of the child's everyday behavior. In Tom's case, for instance, would Tom still have been considered of third-grade caliber if one of the school officials had obtained the following facts?

Tom at eighteen months could supply words in nursery rhymes—*e.g.*, when stimulated with "Little Boy" he would say "Blue". In the third grade he began systematic reading, including Mark Twain's *Tom Sawyer* and *Huckleberry Finn*, the *Book of Knowledge*, the *Boy Scout Magazine*, and *Popular Science Monthly*, his favorite magazine. One day he took

down H. G. Wells' *Outlines of History*. His mother "bet" him that he could not read and explain the first page. He did so, then continued to read until he had finished the first two chapters. In fact he has read many adult books in his parents' library. He is "always ready to pick a fight". His memory is exceptional. Once, while dressing, he placed an open book on his table and shortly had Lincoln's Gettysburg address memorized with the exception of the last paragraph. He can retell stories he heard six months ago, using many of the original words. His observation is acute, his discrimination between words is keen. With a quick, logical mind, he likes to argue; his statements are very positive and are reinforced with illustrations and analogies, often startling in their strength and application to the "point". He plays both alone and with playmates, some of whom are in the eighth grade. His chum is a high-school boy. Together they work a radio-electrical set. A "perfect boy"? Certainly not! No child is perfect. In fact, his parents regret that they can find no signs of musical ability and they fear that he is becoming selfish and dissatisfied because he always craves to do and to learn *more*.

Assuredly, if all the facts about Tom had been known, there would never have been any debate on the question, "Is Tom a child of mental capacity slightly below the third-grade norm?" And it may be added that his parents would have been only too glad to coöperate with the school officials in giving these facts, which are so significant when it comes to "understanding the child".

Illustration of the mistreatment of "superior" children by school authorities must be plentiful in the records of psychological examiners. The writer, for instance, can recall several, one of which is particularly striking. A boy of sturdy and independent bearing had been given special home instruction for two hours each day for several months before entering public school. At the age of six years he entered school in 5C and progressed logically to 5A and to 6C. But, after two months in 6C, the teacher of that grade decided that he was not properly placed, owing to difficulty with handwriting and reading, despite the fact that he had read in the second reader when only three and a half years old! Consequently

the boy was *put back in 4C!* The teacher of the fourth grade, however, believed the boy too bright for the grade and referred him, then eight years and four months old, to the university clinical examiner for mental test. The Stanford-Binet gave a mental age of 15 years and 9 months and an intelligence quotient of 189. Shortly afterwards this mental age was corroborated by the Miller mental-ability test for high-school pupils. In an attempt to adjust matters, the examiner paid a personal visit to the boy's principal, who behaved in a coldly superior and indifferent manner during the entire conference. Nothing could be done. Afterwards, however, the examiner learned of one use that teachers in the school, who were hostile to "mental tests", did make of the boy's test score. They made slurring remarks about the boy's intelligence before his class, implying that he should be able to answer anything because he had such a "high I. Q.". Things like this, in the writer's opinion, are criminal.

In short, this story allows us to make three summary statements: First, a group intelligence test for primary children may prove *too easy* for young children of very superior intelligence. Second, the exceptionally superior child is so rare that when found in a school, he is often not recognized. Third, *a priori* judgments are too readily formed by school officials, and these judgments tend to persist despite conflicting objective evidence.

MENTAL HYGIENE AND OUR UNIVERSITIES*

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THE ideal time for the proper training of the mind is in childhood or during the formative period of life. Of the many cases of mental disease, 40 per cent¹ are preventable. White² states that many mental breakdowns, perhaps the majority of them, occur during adolescence or in early adulthood, and that systematic help extended to the youths in our schools and colleges would be of inestimable value in preventing such breakdowns. Many college students need this help even though to the casual observer there may be no evidence of a nervous disorder. Taft,³ Harrington,⁴ and others have stated that adolescence invariably presents a crisis, and that an adolescence that is not attended by some stress is so unusual that it is almost abnormal; it is a period of transition in which the habits and tastes of the child are being replaced by those of the adult, in which new desires, new interests, and new thoughts are awakened. The adolescent must learn how he may best satisfy or regulate these new desires. If he is unable to adjust himself properly to the new situations with which he is confronted, if he cannot gratify these new impulses, he is apt to turn from the world of reality to a make-believe world in which he can find satisfaction.

From birth, development consists of a long series of adjust-

* Read before the Minnesota Academy of Medicine, December 13, 1922.

¹ See *Organized Work in Mental Hygiene*, by Clifford W. Beers. *MENTAL HYGIENE*, Vol. 1, January, 1917, p. 84.

² *Childhood: the Golden Period for Mental Hygiene*, by William A. White. *MENTAL HYGIENE*, Vol. 4, April, 1920, p. 266.

³ *Mental Hygiene Problems of Normal Adolescence*, by Jessie Taft. *MENTAL HYGIENE*, Vol. 5, pp. 741-51, October, 1921.

⁴ *Mental Disorders in Adolescence*, by Milton A. Harrington. *MENTAL HYGIENE*, Vol. 4, pp. 364-79, April, 1920.

ments between the needs and desires of the individual and the demands of his environment, adjustment consisting in modifying either the one or the other or both. During the adolescent period, this ability to adjust is put to the severest test, for, handicapped by ignorance and inexperience, the youth is required to make more radical adjustments than at any other period of life.

The college student has certain problems of his own to face. He has to make decisions for which he has no precedent. He has to adjust himself to a new environment and to a new group of associates. He wishes to be well thought of by his companions, to stand well in his studies, to be prominent in college activities. He wonders if he should do so and so, or if this or that would "queer" him. He does not understand why he finds it difficult to be his natural self, so that his sterling qualities may be recognized. He may be oversensitive to the remarks or actions of others or he may develop a feeling of inferiority. As a result, he may lose interest in his work and play, find it hard to concentrate, become restless and worried, and develop general physical complaints. oh.

Williams¹ has clearly presented some of the trials of the college student. He says that these experiences are common and that "there is not one of us but has his psychic scars of this period". He goes on to state that a larger number than is supposed develop, as a result of such experiences and their neglect, true psychoses, while a still larger number acquire incapacitating neuroses. Others muddle through, but develop some peculiar warp, the basis of future failure. Williams further emphasizes the great danger of an inferiority complex and states that this may express itself by a characteristic demeanor or by translating the emotion of dissatisfaction with self into dislike of another individual. Continued failure may develop an unsocial attitude, while confidence is developed from continued success.

A certain anonymous writer,² in analyzing his own class twenty years after graduation, says that about three-fourths

¹ *Mental Hygiene and the College Student*. By Frankwood E. Williams. MENTAL HYGIENE, Vol. 5, pp. 283-301, April, 1921.

² *Mental Hygiene and the College Student—Twenty Years After*. MENTAL HYGIENE, Vol. 5, pp. 736-740, October, 1921.

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of the class have shown some neurotic or psychotic difficulty since graduation and that the most marked examples of nervous and mental disorder are found among those who qualified for Phi Beta Kappa, two-thirds of whom are or have been affected with such disorders. In other words, even the most brilliant and supposedly intelligent often need help. Intelligence tests given to 1,500 university students,¹ both men and women, showed that these students were as a whole a highly select group as compared with the rank and file of the population as represented in the army. It is to such as these, above all others, that an opportunity should be given in our educational system to know themselves, in order that they may be able "to size up the present situation and to adjust life intelligently to meet the demands of the immediate circumstances",² and this not only for their own good and happiness, but also for the future welfare of the country.

During the past year I have had occasion to see certain students who, for one reason or another, have been having difficulty with their college work or who have complained of some form of so-called nervousness. Perhaps a brief outline of a few of their histories may be illuminating. None of these cases showed any abnormal physical findings.

One student stated that people seemed to know something about him that he did not know. His friends avoided him and he suspected others of talking about him. This worried him so that he could not sleep or study and had a constant dull headache day and night. He was oriented, but had delusions that were well systematized, persecutory, and quite fixed. There were definite ideas of reference. His explanations were inadequate and his story was not connected.

Another student complained of difficulty in concentrating and thinking. He became depressed and restless, and was not up to his usual efficiency, although he had kept up his studies fairly well. He had had spells similar to this at intervals during the past five or six years. He was engaged to be married and had worried over the fact that he had

¹ See "Results of Intelligence Tests at the University of Illinois", by David S. Hill. *School and Society*, Vol. 9, pp. 542-45, May 3, 1919.

² *The Essentials of an Education*, by Stewart Paton. *MENTAL HYGIENE*, Vol. 4, April, 1920, p. 270.

practiced bestiality as a youth which he feared might have unfitted him to be a husband.

A third had got along fairly well until his graduation from high school, four and a half years before, since when he had apparently lost interest in his studies. He did not know what he wanted to do. The effort of studying appeared to be too much for him, and when he did work, his attention and concentration were poor. He had had to work hard all his life and was earning his way through college. His outside work was such that he had little or no time for any social relaxation, and as a result, he had few friends and kept to himself a great deal.

Another seemed to be suffering from a faulty bringing up. He had never been a good mixer and had always been guarded and protected by his mother. He said that he was "brought up as a sister". For several months he had slept poorly. He dreaded to take up his struggle with the world and would have liked to slide out from under his responsibilities. He brooded over his failure to get everything he wanted out of college. He was introspective, with some feelings of superiority and some homosexual tendencies.

A girl freshman who had never made friends easily had always had an ambition to go on the Shakesperean stage, but as this was opposed by her family, she hoped to become a teacher of Shakespeare and oratory. Early in the school year she fell downstairs, striking her head, and was unconscious for ten minutes. Following this she had dull frontal headaches which prevented her from studying and fell behind in her work. She spent most of her time on history and themes, but had flunked on every theme handed in. She did not like her theme teacher who, she stated, had a sneering smile all the time. As all her sisters had done well in school, the same was expected of her and she was discouraged.

These and others were quite frank cases who sought the student health service voluntarily or were sent by their respective deans, but besides such outspoken cases there are many others who suffer in silence. They carry on as best they can and eventually make some sort of adjustment, but their future life and efficiency may be greatly handicapped by their experiences during this period. Others, of course,

are more fortunate and, either through their own clear insight into the situation or through the aid of close friends in their own class or among the upper classmen or faculty, quickly adjust themselves. However, many students are oversensitive and naturally hesitate to discuss their innermost thoughts with their dean or friends. To whom can they turn for advice? If they do finally report to the student health service, with which many universities are now equipped, they are likely to complain of some physical symptom for which no organic basis can be found and they are frequently told that they are all right. Often it is only when their nervous condition has progressed to a point where there is some outstanding objective evidence of it that they receive real help.

The function of our universities is not only to instill knowledge into their students, but so to equip them that they will be well prepared to face the problems of life. Paton¹ says that the essentials of an education are a knowledge of life, with a definite impelling interest in some phase of it, together with information from actual experiences of one's own capacities for adjustment and one's own limitations, and the cultivation of the emotional attitudes and habits required for recognizing and facing reality. He states that "people who have acquired the essentials of an education are insured against nervous breakdown, do not occupy positions they are not qualified to fill, are not intoxicated by intemperate idealism, do not develop a psychology of life based upon personal grouches or make the fatal mistake of persuading themselves that their own pronounced defense reactions against reality are virtuous".²

here I recently sent a questionnaire to 342 deans in thirty-two state universities, fourteen privately endowed colleges and universities, and eight women's colleges, with the hope of finding out (a) whether any effort was being made by the universities to analyze the causes of students' leaving college, (b) what proportion of the students had mental difficulties as undergraduates or later as graduates, and (c) what was the attitude of educators toward the need for work in

¹ *The Essentials of an Education*, p. 271.

² *Op. cit.*, p. 270.

mental hygiene in the universities, from both the instructors' and students' standpoint, and how the problem of reaching and advising students on this subject might properly be approached. I realized that answers to this questionnaire based on satisfactory statistical figures might not be available, but I wanted at least an opinion based on the educators' general experience with students.

In all, I received replies from 194, or 57 per cent, of the 342. Of these, 19 per cent merely stated that they had no statistics or could not take time to get them together. Another 30 per cent stated that, owing to lack of information, they were referring the questionnaire to another department for answer. Ten per cent of the replies were filled out by physicians connected with student health services, to whom the questionnaires had been referred. In all, 113, or 33 per cent of the possible total, offered at least some comment on the subject.

In reply to the first question, "What percentage of students in college leave or drop a class on account of various causes?" practically no accurate information, except in two or three cases, was obtained from the forty-nine who attempted to give information. "No data" or "Don't know" occurred repeatedly both for this and the next two questions. Where figures were given, they were qualified, almost without exception, by the statement that they were merely estimated.

Improper or elementary training was thought to be the cause of from 1 per cent to 15 per cent of failures to complete the course or to keep up to the required standard, while from 1 per cent to 3 per cent were attributed to the premature attempt to carry on advanced work; some of the replies stated that the students in their colleges were not allowed to attempt advanced work prematurely. The figures for mental inadequacy, as revealed by psychological tests or in other ways, ranged from 2 per cent to 20 per cent. Maladjustment to college life was estimated to be the cause of from 5 per cent to 9 per cent of the failures, though one reply set this figure as high as 25 per cent. Another took the term maladjustment to include "just loafing". Very few students—possibly 1 per cent—were thought to leave college on account of nervous or mental diseases, while .5 per cent to 2 per

cent were said to leave because of physical illness. Economic causes were given as the reason for leaving in from 1 per cent to 5 per cent of the cases. Economic causes seem to play an especially important rôle in certain professional schools, particularly in schools of commercial art and of journalism; one reply stated that 60 per cent of the students in the college in question left to seek work. ‡

Other causes given for the dropping of college work by students were as follows: going to work, 1 per cent; transfer to another college, 1.5 per cent; personal reasons, .7 per cent; hazing, .0019 per cent. Laziness and faulty home training appeared to be the greatest single factor. One prominent university gave statistics for the year 1920-1921 as follows: .1 per cent withdrew on account of ill health, .3 per cent on account of financial considerations, .9 per cent voluntarily or by request on account of low standing, .3 per cent for disciplinary reasons, .7 per cent transferred to another college, and .7 per cent resigned without stating the reason.

As might be expected, the great majority of students who leave college without completing the work do so during the freshman year. Some of the universities accounted for their small percentages of undergraduate failures by their caution in admitting only chosen students.

With respect to the next two questions—"What proportion of students in your college have nervous or mental breakdowns later in life?" and "What proportion of graduate students of whom considerable success was to be expected have become failures or disappointments?"—there were, as was to be expected, no available statistics. The greater number of those who replied were of the opinion that later psychoses were "very few", "negligible", "too small to be important", or "no greater than would be found in any cross section of society". Others felt there were "a sufficient number to merit a thorough study", "probably higher among teachers and professional men", "probably a larger proportion than in the general population". As to failures or disappointments after graduation, the replies varied from "one in ten years" to "5 to 10 per cent". One answer concisely stated: "Too many."

The fourth question was, "Do you believe that proper advice

and guidance—*e.g.*, instruction in mental hygiene—during the university years would be of distinct aid in preventing abnormal nervous reactions during school life or in later years!" Fifty-seven of those who replied believed that such advice would be of help, fourteen stating so most emphatically; eight thought that it probably would; and five doubted it, two of these being connected with graduate schools that require for entrance two or more years of university work. Two thought that such instruction was especially needed in the case of women students, one adding that "a common-sense dean of women with a medical education could do a lot". Another stated that the question assumed that the students did not now get such advice, "an unwarranted assumption" so far as that particular university was concerned.

The next two questions dealt with the problem of determining which students needed such guidance and to whom they should be referred. The large majority felt that these students could best be sought out through personal observation and intimate contact with instructors and preceptors; others recommended physical and mental examinations with psychological tests or a study of their pasts and their family histories. Two suggested that the best method would be to make it generally known that such advice and guidance were available. Extracts from a few of the more illuminating replies follow:

"It is difficult to discover cases early, owing to the tendency of students and others to suppress outward manifestations. This is probably stronger in persons of the intellectual level of students than in others." "In conference, primarily about other things." "By observing social relations to other students, their reaction to an appeal to their reason, and the manner in which problems involving pure mental vision are attacked." "By personal daily knowledge of the students and information from preceptors and in certain instances by special medical advice." "Do not believe any special mechanism can be devised to get hold of these students." "By each instructor having a working knowledge of mental hygiene, so that he can refer cases to the college physician." "By (a) questionnaires sent to families of those entering for information from the family and their physician concerning

the entering student's health, (b) careful medical examination of all undergraduates, and (c) reports of instructors and counselors concerning students who are nervous, having difficulty in adjusting themselves to their environment, or who are doing poorly in their studies."

Forty-five of those who replied would refer such cases to the university health service or to a specialist; ten to deans or instructors; four to both health service and the deans; three to a psychologist; and three to both a physician and a psychologist. The difficulty of finding an advisor with the proper training was mentioned by a number.

As to the part that extra-curriculum activities play in causing nervous breakdowns, failures in studies, and the like, thirty-three felt that these activities are an important cause of failure, although a number stated that they are helpful in preventing breakdowns as they tend to provide a varied and well-balanced life. Five had observed no evidence of ill effect from such activities. In the professional schools they appear to play a minor part as compared to their rôle in the undergraduate colleges.

As to whether mental hygiene was sufficiently important to be taught as a required subject in the individual colleges, twenty-nine answered "yes", some quite emphatically, while seventeen others approved if it were included as a part of the course in physical hygiene. Four believed in a course in mental hygiene if the proper person for giving it were available; a number of others mentioned the necessity that such a course should be given only by an expert. Seven questioned the advisability of a required course in mental hygiene. Two felt that such a course might be given as an elective only. Twenty were opposed to it. Among these last were four connected with graduate colleges.

Fifty-eight were of the opinion that an instructor should have a knowledge of mental hygiene for the sake both of the students' and his own welfare; three thought it desirable from the students' standpoint alone; three from the teachers' standpoint alone; four questioned the desirability from the standpoint of student welfare; and five doubted whether it would be of any benefit to the instructors. Two denied any benefit to either the student or the teacher, and one believed

it too important a subject to place in the hands of half-trained persons.

Under general remarks, there were some very interesting and enlightening statements. Twenty expressed themselves as being interested in mental hygiene as it related to the university. Eight of these, only one of whom was a dean of medicine, stated that it was of vital importance, and one went so far as to say that "if mental hygiene means what it seems to mean and actually exists, it is the most important thing in the world". Seven colleges are attempting at present or hoping soon to start work along this line. One stated that "there was some danger in publicity in these matters among even intelligent administrative officers and teachers, as it was an easy matter to create in a community a public sentiment tending not only to the discovery, but the promotion of mental aberration". Another believes that "this is one of the most important responsibilities of any college, as maladjustments account for much of the failure in the freshman year". A third says that "schools and colleges seem to be only at the beginning of work in this important field and that the difficulties of educating college students, faculties, and students' families as to the need of this work seem very great at present".

In contrast to these opinions, another feels that mental hygiene might be useful, but it is his conviction that the college needs picked students, as there is "a terrible waste in trying to educate every one who enters". A medical director writes that a lot of nervousness is traceable to inferior living conditions and poor meals, prepared by the students themselves, together with the necessity of earning their way through the university, which results in lack of social and campus life. This was considered particularly true of women.

Some of the answers from the graduate schools emphasize the point that mental hygiene is probably not needed among their students, as they have had an opportunity to become adjusted during their undergraduate life. However, one dean of graduate education believes that the subject is "a most important one and possibly the most important aspect of hygiene in our universities". Two others feel that "it might be of considerable practical importance" and that "it is one

of the most significant and neglected aspects of education". Another states that "a little learning is a dangerous thing and more dangerous in this than perhaps any other field of education; that it would be most advantageous and useful if the whole teaching staff might be given instruction as a class in mental hygiene". Two or three very frankly state that they do not know what mental hygiene means.

It would appear from the answers to this questionnaire that accurate statistics are needed to determine the reasons why students leave college, not only for the sake of the individuals concerned, but that, by a careful analysis, the university may know if it is doing all that it should for its students in preparing them to meet their present and future problems.

That many attempt a college education who are unfitted for it is granted, and without question these students should be sorted out early and advised, so far as possible, as to the niche in life they can best and most contentedly fill. But of the others there are a certain proportion, probably a large proportion, who at one time or another do need a certain amount of guidance.

A brief neuropsychiatric examination of 1,141 college students undertaken at an Eastern university revealed that 16.4 per cent gave a history of one or more of the following troubles: abnormal moods or difficult adaptation; nervous symptoms in the past; convulsions; chorea; bedwetting; night terrors; sleep walking; stammering; severe nervous breakdowns, or nervous symptoms at present. These students differed physically from those with no such histories only in more frequently showing exaggerated knee kicks, rapid heart beat, and other vasomotor phenomena.¹

The question how to reach students at the opportune time and how best to advise them is tremendous. Many voluntarily seek assistance and advice in their affairs, over four hundred going to one dean to discuss finances alone.² It is reasonable to suppose that they would be equally ready to seek help in

¹ See "A Report on the Brief Neuropsychiatric Examination of 1,141 Students", by Stanley Cobb. *The Journal of Industrial Hygiene*, Vol. 3, February, 1922, p. 311.

² Dean Nicholson. See *Minnesota Alumni Weekly*, Vol. 21, May 11, 1923, p. 464.

regard to their mental and emotional problems, if they knew that such help was available.

The problem, however, is one that is by no means limited to the undergraduate. As Singer¹ has pointed out, there are at least three groups of professional men whose special business it is to give advice regarding disorders of behavior and social maladjustments—physicians, lawyers, and clergymen. That their advice may be based on certain fundamental truths, it is necessary that they should receive instruction in the general principles of social behavior and mental health.

It is unfortunately true that one of the greatest handicaps that has to be faced at present in the mental-hygiene movement is the limited number of persons who are fitted to give instruction in this subject, but, even so, some effort should be made to introduce mental hygiene in a practical form into our higher institutions of learning.

It is with considerable hesitation that I make any suggestions as to how this problem should be approached. The following are offered only tentatively:

1. The establishment in every university of a well-equipped students' health service connected with which should be a neuropsychiatrist, preferably one who has had special training in this work.

2. A careful and complete physical examination, including that by a neuropsychiatrist, of every student at least once each year. At his first examination, on admission, a complete family and past history, as well as a history of his present complaints, should be secured, analyzed, and filed. Part of this history might well be furnished by the family.

3. The instruction, possibly by visiting lecturers, of professors and instructors in the elementary principles of mental hygiene, not only for their own good, but also that they may recognize early, and understand, evidences of failure to acquire habits of behavior that are necessary for proper social adjustment.

4. The division of classes into small groups, with each

¹ *The Need for Instruction in Mental Hygiene in Medical, Law, and Theological Schools*, by H. Douglas Singer. *MENTAL HYGIENE*, Vol. 3, pp. 24-32, January, 1919.

individual of which an instructor will be in close contact, not only in class work, but socially as well.

5. And last, but not least, the encouraging of the individual student to take the initiative and seek advice and help from his instructors, dean, and health service.

If our universities can so equip their students that they will be able to "adjust life happily and successfully"¹ they will be accomplishing a work of inestimable value for future generations.

¹ Paton. *The Essentials of an Education*, p. 230.

THE REACTION OF COLLEGE STUDENTS TO MENTAL HYGIENE

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THE mental hygiene of the college student has received a certain amount of attention, but little from the college authorities themselves, or, for that matter, from any one connected with the students in a fairly intimate way. Yet those who are familiar with mental hygiene in its broader connotations and who are on close enough terms with college students to receive their confidences can report startling conditions among the group represented by them.¹

Granting that there is a need for instruction in mental hygiene among college students, we come to the question, just where can they obtain such instruction and guidance? The dean naturally occurs to one's mind first. But do Greek and mathematics, even plus good intentions, prepare one for serving in such a capacity? In colleges and universities that have no department of neuropsychiatry there remains only the department of psychology as a source of this information and guidance.

For the time being, we will confine our discussion to the question how the department of psychology can best dispense this information. Conferences naturally suggest themselves. But who can spend much time in conferences when a schedule of more than twelve class hours a week faces one for thirty-six weeks of the year? And how, moreover, can the students who are in need of such conferences be brought to the attention of the psychologist?

I have tried to solve this problem in a rather simple way by devoting the last six weeks of an elementary course in psychology to instruction in mental hygiene, especially as it affects the college student. This plan has been tried out, and

¹ The writer is completing a survey of college students from this angle. The findings are amazing and will be published in detail with case reports as soon as the data can be worked over.

successfully, with a class of seventy students, who, after receiving instruction, acted as missionaries to bring in other students with whom the department did not come into contact, but who seemed to the students in the elementary course to be in need of instruction.

The orthodox, already confronted with the iconoclastic behaviorists, may react with horror to such an innovation in the elementary courses in psychology. Accordingly it may be well, before discussing the organization of this instruction and the reaction of the student body to it, to state the psychological justification for such a departure from tradition.

Any one who reads the advertisements that talk up the wonderful value of advertising and still keeps his scientific attitude toward them soon realizes (quite apart from paranoid tendencies) that there is a great conspiracy afoot, which seems to center around the sale of advertising space. If one can face facts as they are and not resort to a flight from reality, it becomes apparent that there is much the same great conspiracy afoot relative to the value of a college education. Mathematics is no longer taught as the sharpener of the wits. Mental discipline has gone by the board. It seems that intelligence is not increased one whit by absorbing four years of a college education.

We have left, as the objects of a college education, culture and practical information. As to the first, rare indeed is the college student of the present day who has received even the barest inoculation of culture. Most college students cannot tell whether the band plays it or whether it is a salad. And what is there that might be construed to be of cultural value in a course in psychology? Some odds and ends of information, smacking strongly of a queer blending of physics, physiology, and philosophy, without which there is little left of the psychology textbooks.

There remains useful information. Can psychology courses supply that? From the brief experience of the writer, he would emphatically state that *it can*. The unfortunate thing is that the elementary courses too rarely do supply it. In trying to justify the teaching of college courses in psychology, to take for granted that a subject is necessary is no less than tyrannical. To justify it on the ground that it increases one's mental powers is absurd. If it can be justified at all, it is

because some practical good will come to the students as a result of spending three dry hours weekly in listening to a learned instructor gradually unfold the mysteries of nerve tracts and animal learning. Any other attitude toward this—or any other college course, for that matter—is largely a defense reaction.

It is from this point of view that the writer has attempted to conduct the elementary psychology course so that it will be of the greatest practical usefulness to the unwary students who eagerly register for the course because they have read *Success Magazine* and been impressed by the advertisements therein. This is my justification for devoting the last six weeks of that course to mental hygiene.

No attempt has been made to force any conceptions of value or interest upon the students. The writer realizes only too keenly that what is of the greatest research interest to oneself is too often assumed to be of interest and intense value to the budding student. Rather the attempt has been to let the students decide for themselves what is of most interest to them and what has struck them as being of the greatest value in the course.

Two queries on this subject were addressed to a large class in psychology after they had completed the usual course, well over a third of it devoted to sensations and sense organs and the remainder to structural psychology of the thinking-feeling-doing, sensation-perception-conception-judgment-reasoning type. A summary of their replies follows:

Topic	Votes for interest	Votes for value
Experiments	1	0
Attention	2	1
Æsthetics	4	1
Philosophical basis	1	1
Sensations	4	6
Learning	1	16
Emotions	5	5
Instincts	1	0
Abnormal psychology	56	17
Heredity	10	11
Criminology	5	1
Applied psychology	29	41
Habits	1	0
Mental structure	0	2
Animal behavior	0	2

There is a slight relationship between interest and estimated value of the topical divisions of this course. The correlation between the two orders is .33. This may invalidate the value judgments somewhat. Between interest and amount of time spent on a topic, however, there is a high negative correlation. A large amount of the time was spent in experiments, which received only one vote in interest. By far the most time devoted to any single topic was given to sensations; it, also, ranks low in interest. Abnormal psychology was covered in two lectures at the most; this topic ranks highest in interest. All the other topics might be taken up in detail to show the same inverse relationship between time and interest.

In comparing values and time spent on a topic, the same holds true. There are no value votes on experiments, and many value votes on abnormal psychology, even though the latter touched upon mental hygiene and "normal abnormal" conditions very remotely.

It was the results of this balloting that caused the radical remodeling of the course that the writer has given this year. Applied psychology, abnormal psychology, and learning were emphasized. Heredity was voted high by the students, but it was left out of the course this year because heredity properly belongs to another department, and the writer has found that, even with this interesting and admittedly valuable topic omitted, the course was still crowded with pregnant material. This omission was made reluctantly and in spite of the fact that animal biology has been the writer's field of minor interest and that he has contributed several articles to the physiological and medical journals on this topic.

In looking over the results of the ballots on interest and value, one is struck with the immense preponderance of abnormal psychology in view of the limited time that was given it and the fact that it dealt rather with clinical entities than with the more practical facts that might be supposed to have bearing on the activities of college students. In emphasizing abnormal psychology in the elementary course this year, study was directed rather along the line of normal psychopathic conditions (pardon the apparent contradiction!) than to the psychogenesis of the psychoses.

The present report is concerned chiefly with the six weeks that were given to the general subject of mental hygiene. It is preliminary to other reports which will deal more intimately and personally with mental hygiene and the college student.

First, let us take up the readings and lectures given under this general topic. The following books and articles, listed in the order read, were assigned for reading by the students, while in the class hour the instructor took up in detail Prince's *The Unconscious* and *The Dissociation of a Personality*:

- Brill: *Fundamental Conceptions of Psychoanalysis*. New York: Harcourt, Brace, and Company, 1921.
- Coriat: *Abnormal Psychology*. New York: Moffat, Yard, and Company, 1917.
- Jackson and Salisbury: *Outwitting Our Nerves*. New York: The Century Company, 1921.
- Report of the Mental Hygiene Survey of Cincinnati. Cincinnati: The Mental Hygiene Council of the Public Health Federation, 1922.
- Williams: *Anxiety and Fear*. MENTAL HYGIENE, Vol. 4, pp. 73-81, January, 1920.
- Myerson: *The "Nervousness" of the Jew*. MENTAL HYGIENE, Vol. 4, pp. 65-72, January, 1920.
- Gilbert: "Amnesia—The Subconscious Warehouse." *Medical Record*, Vol. 99, pp. 127-33, January 23, 1921.
- Paton: "The Psychology of the Radical." *The Yale Review*, Vol. 11, pp. 89-101, October, 1921.
- Parker: *The I. W. W. Essay in The Casual Laborer*. New York: Harcourt, Brace, and Howe, 1920.
- Pruette and Fryer: *Affective Factors in Vocational Maladjustment*. MENTAL HYGIENE, Vol. 7, pp. 102-18, January, 1923.
- Spaulding: *Three Cases of Larceny*. MENTAL HYGIENE, Vol. 4, pp. 82-102, January, 1920.
- Paton: *The Essentials of an Education*. MENTAL HYGIENE, Vol. 4, pp. 268-80, April, 1920.
- Williams: *Mental Hygiene and the College Student*. MENTAL HYGIENE, Vol. 5, pp. 283-301, April, 1921.
- Anon: *Mental Hygiene and the College Student—Twenty Years After*. MENTAL HYGIENE, Vol. 5, pp. 736-40, October, 1921.

In addition to these readings, one student reported on Beers' *A Mind that Found Itself*, and a lecture on shell shock was given by Dr. Harold E. Foster, who was at the time directing the Wyoming mental-hygiene survey. The instructor lectured only on the two books by Prince. The remainder of the class time was spent in discussion of the topics as they were read. The students prepared two papers touching on the mental hygiene of the college student. One, the first, was a personal analysis and examination. The other was a study

of some student in the university whom the person writing the paper had known in high school. In the second paper we have a study of some seventy students before and after taking a small dose of college life and education. In certain respects the findings of this survey which the class made of mental hygiene in the university even outdo those of the Cincinnati mental-hygiene survey. These findings will be discussed in the next report.

Did the students report this work as interesting and of value? The following digest of their ballots is sufficient answer:

<i>Topic</i>	<i>Votes for interest</i>	<i>Votes for value</i>
Mental hygiene	68	67
Learning	0	1
Individual differences	1	1
Imagination	1	0
Dreams	0	1

It was not a case of the most recent topics being enhanced in interest. In the review period, all phases of the course were rehashed and the students were notified two weeks ahead of the balloting and reminded at each following class hour that the ballot was to be taken.

SUMMARY

College students are eager for instruction in mental hygiene, especially as it affects them personally. It was estimated to be of more value than any other part of the course in elementary psychology. That it results in much personal benefit is shown by the results "before and after taking", which will be reported in detail shortly.

THE NON-SPECIFICITY OF MENTAL DISEASE

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PSYCHIATRISTS of the present day and generation have been the recipients of many plausible explanations of the origin and phenomena of mental disease. The theory of focal infections, with the teeth as the favorite locus, and the recent enthusiasm over the etiological possibilities of the endocrine organs, are two instances in which the method of approach has been frankly and somewhat empirically along rather restricted organic lines. The exploration of the unconscious and the doctrines of repressions and conflicts, of organ inferiority, and of the cravings of the autonomic apparatus, are types of theories that either have had a clear-cut psychogenic objective or have sought to reach their goal by various ingenious and sometimes valuable modes of reasoning that aim to span the gap between the organicists and the functionalists.

At the outset it should be stated that psychiatry owes a large debt of gratitude to those who have promulgated the new doctrines. They have given tremendous impetus to the study of mental disease. Enthusiastic disciples have not been wanting, and the psychoses have been the subject of most intensive and exhaustive investigation. If sometimes a devoted, but somewhat regrettable singleness of purpose has detracted from the scientific worth of the result, it is still not a total loss. There is yet time for correlations. It seems fair to write on the credit side as a permanent gain the advance of our specialty beyond the narrow confines and sterile concepts of a rigidly objective and descriptive psychiatry. Certain of the clinical phenomena that recur so frequently in mental illness have been adequately and logically explained. Finally, the benefits that have accrued to the individual patient are not altogether negligible. Of course, since the various theories

are often diametrically opposed in their dogma and methods, one must conclude that at least some of them contain a margin of error. Yet this does not constitute an insuperable obstacle to therapeutic progress. The very divergence of opinions inevitably means that attention will be focused on the problem from several angles, and the system of trial and discard should eventually provide newer and better standards of treatment.

It is perhaps unfortunate that the advocates of these new systems or schools have always insisted, either openly or by obvious implication, on the doctrine of what may be termed the specificity of mental disease. The student is sometimes left with a confused feeling that he must either accept this or that viewpoint or abandon it altogether and strive for a newer article of faith. Possibly this is due to the fact that certain utterances and writings, which by their very nature must still remain theoretical and problematical in the present state of our psychiatric knowledge, are brought forward as final and absolutely established criteria and clothed with all the dignity of infallible *ex cathedra* rulings. After all, this is a very human failing and bespeaks merely sincere enthusiasm. However, the general effect is not always constructive. One may have in mind a number of more or less carefully studied cases in which the evidence seems overwhelmingly in favor of physical factors as causative—or, better, precipitating—agents, and another series in which the mental disease seems to have been produced or certainly favored by psychogenic instrumentation. What is one to do when involved in such a predicament? Is it right to abandon a hard-won conviction, even though it may apply to but a single patient? May it not be possible that the difficulty of reconciling two seemingly inimical viewpoints arises not because one is inherently correct and the other inherently wrong, but because, under certain given conditions, they are both true? In other words, may we not find in the last analysis that there is such a thing as multiplicity of causes as applied to mental disease—a *non-specific etiology*?

NON-SPECIFICITY OF DISEASE IN GENERAL

In attempting to make clear the premise of the "non-specificity" of mental disease, it may be worth while to turn

for a moment to the domain of general medicine. The pathological conditions that can be described as distinctly specific reactions—i.e., always ascribable to well-known and clearly demonstrable causes—are after all quite limited and certainly are easily outnumbered by those morbid states in which the etiology is a matter of doubt and conjecture. Again, one thinks readily of tuberculosis, syphilis, typhoid fever, malaria, and the like, as phenomena that, from the standpoint of causation, have been scientifically tested and proven for all time to come. However, medicine is an art and not a science, and from the criterion of definite cause and unavoidable effect it is not possible to grant, for instance, the absolute specificity of tuberculosis, even though its clinical and pathological limits may be drawn with considerable accuracy and its source is indisputably the bacillus of Koch. It may seem trite to remark that many individuals come into close contact with this organism, but escape consumption, and yet, from this and similar observations, one gains the broader conception of the fallaciousness of thinking in terms of unconditioned specificity. If the presence of the bacillus tuberculosis inevitably meant the development of that disease in an individual, if the pneumococcus, the spirochete pallida, or the bacillus of typhoid fever implied that the necessary outcome must be pneumonia, syphilis, or enteric fever, then indeed it might be profitable, not only in general medicine, but also in psychiatry, to devote exclusive attention to a search for single disease-producing agents. However, in all probability the processes that lead to the development of any morbid condition are immensely complicated and closely related to one another, and disease is almost always the culmination of a long series of more or less detrimental or destructive conditions which eventually become sufficiently strong to break down the barriers of natural and acquired resistance. The tremendous importance of even such general considerations as age, race, climate, nutrition, occupation, hygiene, habits of life, and the like, cannot be overemphasized, and even though it is often true that such general factors would be powerless to produce morbidity in themselves, if the direct mediation of a specific cause were wanting, still it is probably also true that without their predisposing influence, this cause in itself

would not exert any harmful effect. These general factors are so well known that we are accustomed to speak of racial, climatic, occupational, adolescent, climacteric, or senile diseases, and the like. By this we do not mean to imply that they are rigidly restricted to certain races, climates, occupations, or age periods, but that these factors in combination with others—among which may be included a more or less clearly understood causal agent—are most frequently encountered in tracing the incidence of the diseases in question. Even such a seemingly simple occurrence as a fracture of a bone may be and often is due to remotely determining circumstances. The age of the individual, the fragility of the bone, or the presence of constitutional disease may in a given instance be much more important and motivating than the actual force of the impact.

It would seem, therefore, that in some sense we are always dealing with total reactions which are the end result of the constant interplay between individual and environment. Furthermore, if it is permissible to speak of the "chances" of contracting any given disease, it is manifestly obvious that there are no two stages in an individual's existence when the "chances" are exactly equal, even though he is at both times in contact with the disease-producing organism. His resistance is either greater or less at one time than at another, and its strength is dependent upon the addition and subtraction of all the upbuilding and deteriorating conditions of his whole life. Thus, at twenty a man may escape tuberculosis, even though he is exposed to the bacillus, because he has led an outdoor, hygienic life and is in excellent physical state, but he may succumb at thirty, owing to reduced resistance due to sedentary occupation, insufficient food, fresh air, and sunshine, and perhaps alcoholic overindulgence. It is even hypothetically plausible to conceive of two human beings who, by reason of previous circumstances of life, are equally protected from or exposed to infection, and yet the one falls ill and the other successfully resists because in the latter hereditary influences are an asset while in the former they are a liability. Heredity may sometimes act directly, as in the instance of inherited syphilis; more often it is non-specific, as when the stock is more distantly weakened by alcoholism or syphilis.

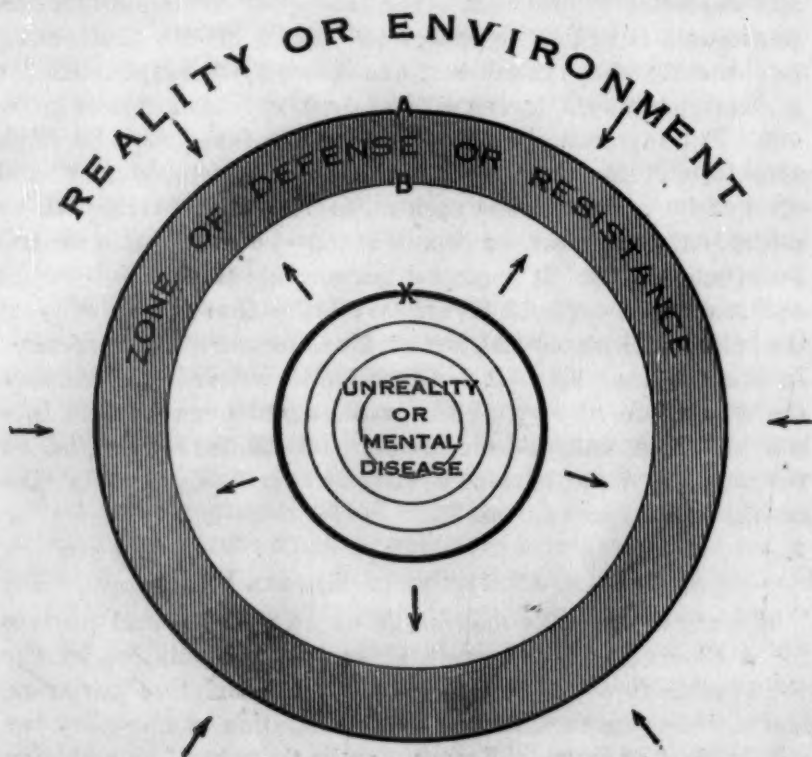
Not only may antecedent factors have a definite value in conditioning the development of disease, but the chronological order of their occurrence sometimes may be decisive. Thus, an individual may go on a debauch and after a period of sobriety be exposed to cold and inclement weather and still continue in reasonably good health, while if the drunkenness and exposure follow each other closely or are simultaneous, pneumonia is apt to be contracted. It is always fascinating to speculate on the considerations that may be responsible for the seriousness or degree of disease after it is actually present. For instance the course of enteric fever may be mild, smooth, and uncomplicated, or it may be severe, stormy, and marked by complications such as hemorrhage, peritonitis, or meningeal symptoms, or finally it may be overwhelming and eventuate fatally. It is almost permissible to speak of benign and malignant typhoid fever. We know that the severity of the infection is influential, but surely there are other influences. In the last analysis is it not feasible to weigh in the balance the whole life history of the patient and even to take into consideration remote ancestrally determined strengths or weaknesses of the various systems of the body, such as the cardiovascular or nervous?

THE NON-SPECIFICITY OF MENTAL DISEASE

The above remarks may serve as an apology and preface for a theoretical and purely schematic presentation of the non-specificity of mental disease. For descriptive purposes, insanity may be regarded as the substitution of unreality for reality, just as organic disease may be thought of as a change from an organically natural to an unnatural or diseased status. Of course, I realize that there is no merit of originality in this conception; at most it is a helpful method of studying the individual patient from several angles and one that is least prone to lead to errors of omission.

The circle *A* in the following chart (page 282) symbolizes the individual's contact with his environment or reality. It is, of course, understood that there is never perfect contact—that is, there is never absolute normality—but the conventional circle makes easier the conception of the delicately adjusted and at least outwardly maintained balance between indi-

vidualization and socialization that constitutes sanity. Inside the circle *A* a second circle *B* is arbitrarily drawn, and the zone included between these two signifies resistance, or the amount of defense that is available in keeping the outer circle or the individual evenly adapted to the world in which he lives and moves. This zone is necessarily



a very variable quantity. In the beginning, or at birth, its initial thickness may be considered as the product of favorable or unfavorable hereditary influences of all kinds. Thereafter it is constantly changing—being added to or subtracted from in response to every experience and exigency of life. These experiences or conditions, which may be either upbuilding or inimical, spring largely from reality or the environment, and embrace the widest range of conceivable possibilities. To enumerate them one would be obliged to trace every environmental occurrence, both physical and psychogenic, from the first day of infancy to the instant of death.

Even apparently insignificant happenings are capable of producing some slight alteration. Although the defense sector is never static, yet its amount or thickness cannot be suddenly and artificially increased. Well inside the zone of defense is placed a small circle X, which represents unreality or mental disease and which includes a number of still smaller circles to indicate differences in the intensity of the disease process or benign and regressive stages and types of abnormality.

With this schematic presentation in mind one may consider a number of contingencies. For instance, it is not unlikely that a notably defective ancestry may reduce an individual's resistance to such a minimum that the first environmental thrust is sufficient immediately to bend the outer circle of normality into unreality or a psychosis. At times the process is seemingly gradual and a long period of accumulated stresses, both physical and mental, are required slowly to diminish the solidity of the defense zone and curve it toward unreality. Again, it is not unlikely that the close chronological sequence of strains and the time of their occurrence may prove too much for the amount of resistance available at a given period. If separated by an interval of time, they may be turned aside. Thus, Mary Jones at twenty-five may be able to meet successfully an attack of influenza, at thirty she may mentally survive the unfaithfulness of her husband and desertion, and at forty-five she may overcome the deleterious influence of the climacteric, but were all these events to occur practically simultaneously, she might not be able to withstand their combined destructive effect. Thus, by varying the type, severity, and time of appearance of the precipitating situations, increasing their number, or arranging them in close chronological sequence, one is able theoretically to diminish resistance to the vanishing point. In this connection it may be stated, from the standpoint of practicability, that it is scarcely possible to lay down hypothetical premises or conditions that have not been fulfilled and are not being reproduced in the actual life history of human beings.

Once a psychosis has become established, what is it that determines recovery or prevents it? There is, first, the benign or malignant character of the specific etiological agent which in psychiatry, with but few exceptions, still remains unascer-

tained. Resistance has still to be considered. Clinical psychiatrists are constantly meeting cases in which the prognostic indications are set aside and an apparently favorable psychosis becomes chronic, or vice versa. Is the reversal of expectation entirely a question of diagnostic error or is it at times conceivable that in one patient there is practically nothing available from previous conditions of life or heredity that may assist in a return to reality while in the other there are unexpected resources which may be powerful enough to stem the current?

It will be seen that specific causative agents are in no way excluded by the ideas that have been so briefly and incompletely outlined. For instance there can be no question as to the specificity of paresis and yet the number of syphilitic patients who develop the disease is comparatively limited. It is reasonable to assume that additional modifications must be present before the spirochete can invade the brain tissue, and these modifications are probably to be sought in the individual and his environment and not in the spirochete. If the problem of schizophrenia or mental disease should eventually be worked out with the same completeness as that of tuberculosis, we could still not afford to discard the broader concept of non-specificity unless we were willing to be satisfied with an inadequate explanation.

CASE HISTORIES

In order to carry the argument somewhat further, fifteen cases are presented. They were not particularly selected, beyond the requirements of a reasonably complete history and the fact that it was deemed advisable to have representatives from a number of life decades. The onset of the psychosis in three instances falls in the second decade, in three in the third, in three in the fourth, in three in the fifth, and finally in three in the sixth or beyond. The case records cannot be given in any detail and merely the most salient features are outlined.

Case 1. Mary Brown, aged nineteen, presents a psychosis whose symptoms are decidedly characteristic of schizophrenia. When last observed, she had periods of catatonic excitement, was violent, resistive, and destructive, with a silly, inappropriate affect reaction and auditory hallucinosis, and had regressed to an infantile level. She was untidy,

lisped in a babyish manner, called the physician "mamma", and said, "Children act this way."

When we examined the immediate pre-psychotic history, we failed to find any external precipitating factors. An analysis of the determining character traits was more fruitful. Even as a child, Mary was self-willed, dramatic, affected, passionately attached to her teachers, but also sensitive and *seclusive*. Reality did not deal softly with her. Her father disclaimed all responsibility for the family and deserted her mother when Mary was nine years old. Society then moved the waif about from home to home; there were eight placements between the ages of nine and fifteen. At sixteen our patient was arrested for vagrancy. Three years later the psychosis appeared. A step further back brings us to a consideration of Mary's ancestry. The paternal grandfather was habitually in jail. The father was an epileptic and ne'er-do-well. The mother, a maternal uncle, and a sister are in state hospitals with dementia praecox. A younger sister is psychopathic.

Could Mary Brown have escaped mental disease, no matter how pleasantly her life had been placed? Was not her mental disease predetermined by a hopelessly defective immediate and remote ancestry?

Case 2. Virginia Green developed mental disease abruptly at the early age of nineteen. On the basis of a shallow, rather silly, apparently insufficient affective reaction, hallucinosis, and catatonielike outbreaks, the consensus of diagnostic opinion was in favor of dementia praecox. The fact that the patient recovered in three months, is now married, has a child, and has succeeded in accomplishing a life adjustment, does not negative the opinion that the disease process was clinically essentially a schizophrenic one.

Virginia's maternal grandfather was a senile dement, a maternal uncle was insane, and a maternal aunt is peculiar. Otherwise the family history is not unusual.

Virginia was handicapped by being an only child. As is often the case, she was also a "nervous" child, presumably because her attention was more or less constantly focused on herself. She was naturally bright, pleasant, and affectionate, but "all her life she has been petted and humored and never crossed in any way". She became angry when any one interfered with her wishes. She was quiet and sensitive, but social. On the whole, Virginia found the world a pleasant place to be in, and her environment was always plastic enough to be molded into any shape that suited her whims. She got on with a minimum of inhibitions.

She became engaged to marry, and retrospectively we have learned that she also became illegitimately pregnant. This was the first seriously unpleasant situation in which she had ever found herself, and without confiding in any one, she sought to extricate herself by having a criminal operation performed. Products of conception were retained and septic infection developed with acute urinary suppression. The uterus was again emptied, but in ten days the patient began to laugh immoderately, had crying spells, hallucinated, and became violent.

Is it not likely that the precipitating factors that determined the break from reality were these two: first, the mental crisis incident to finding herself illegitimately pregnant and the retention of this knowledge secretly, and, second, the physical insult of severe septic infection? What was back of this that made it possible for mental disease to develop? Is the somewhat impaired ancestral line sufficient to account for it? Is it not rather more reasonable to assume that detrimental environmental influences of childhood, adolescence, and early maturity left Virginia totally unprepared to grapple with the first serious strain directed against the contact of her personality with reality?

Case 5. Frances White obviously has dementia praecox. She broke down at the age of nineteen. At the present time she seems almost without affect life; at best there is inappropriate silliness. Her psychotic life is on an infantile level. She acts and speaks and eats like a baby. The present regression and the beginning of the psychosis are connected by a period of typical schizophrenic catatonic stupor.

Frances is the daughter of a long-lived Southern family of good standing in the community and of excellent antecedents. She was a happy, good-natured, docile, affectionate, and healthy child. At seventeen she entered college and was average in her studies, fond of dancing, athletics, and outdoor life, and was voted the best-dispositioned girl in her class. The important events that preceded the psychosis took place within a period of a few months. She was disappointed because a young man in whom she was interested went to France and stopped corresponding with her. Soon after this she became ill while attending a dance, but concealed her illness rather than miss another dance and probably went about for three days with a high fever. She developed influenza, was confined in bed for ten days, and apparently recovered. However, a few weeks later a heavy cold developed, and Frances began to lose weight and show "nervousness". She spoke of pains in her eyes, became seclusive, and had crying spells. A temporary period of improvement was followed by renewed complaints of "shooting out" sensations in the eyes, other subjective somatic discomforts, and finally definite psychotic manifestations—dreaminess, depression, resistiveness, and hallucinosis. It is of some interest that from time to time there appears transient, but quite definite ocular strabismus.

Are the interest in a young man and the disappointment that followed the cessation of social relations with him sufficient to account for the development of mental disease in an apparently normal, healthy young woman? Was the mental disease conditioned by influenza which perhaps had as a sequel encephalitis?

Case 4. Yetta Cohn developed acute mental symptoms during her twenty-third year. At staff conference there was but one dissenting opinion from the diagnosis of dementia praecox. A disproportionate affective reaction and episodic catatonic behavior were featured. The patient's condition is practically unchanged.

Yetta springs from Russian-Jewish ancestry. The family had no mental liabilities and the father was an intelligent, able, and successful man. Yetta came to this country at the age of ten. She was the third of four sisters and two brothers, all of whom have demonstrated their ability to overcome easily the handicaps that fall to the lot of the emigrant. The patient attended school in Russia and completed her education, which carried her through one year of high school and two years of business college in this country. Unusually quick and bright, Yetta was an efficient worker and satisfied the requirements of a large corporation which was quite willing to retain her as a trusted employee even though she had to work somewhat irregularly on account of continued poor health. She was kind and ambitious and social. On the other hand, as personality drawbacks, there were sensitiveness, a tendency to worry, and constant self-dissatisfaction because she could not attain to too highly placed ideals.

Since impaired physical health seemed to play an important rôle as a deterrent to a complete realization of Yetta's potential possibilities, it might be well to review her physical difficulties in detail. She suffered from irregular menstruation and considerable dysmenorrhea, which at sixteen became associated with severe digestive disturbances and intense headache; at twenty an operation for appendicitis and floating kidney was necessary; at twenty-one she succumbed to attacks of influenza, pneumonia, and pleurisy; and seven months before the mental illness, there was a recurrence of pleurisy and pneumonia. The initial attack of influenza and pneumonia was preceded by the death of a favorite aunt and succeeded by the death of her brother.

After consulting a neurologist, she telephoned him, impersonating her sister, and was told that there was a possibility of insanity. At once she became restless, agitated, suicidal, and refused food.

Is it not true that Yetta Cohn's character traits in themselves were not inconsistent with continued normality? Is not the struggle to attain highly placed ideals not only exceedingly frequent, but also often satisfactorily adjusted? Is it not, in fact, a valuable energizing life principle? May it not be assumed that in this instance the obstacles were so frequent and so serious that they made even partial accomplishment a hopeless task? May not these obstacles be largely summed up in the physical liabilities which the patient sustained? Did not the fact that the acceptance of failure was too difficult for Yetta Cohn's make-up eventually determine the crumbling of her resistance and the break from reality?

Case 5. Pearl Wilson is now in a state hospital. Mental disease appeared acutely at the age of twenty-five. Even at the end of the first year of the psychosis, the diagnostic opinion was still evenly divided between a manic-depressive and a dementia-praecox process. An apparently benign stupor, together with the intrusion of depressive trends or distractibility and flight, probably served to mask an underlying and increasing silliness and inappropriate affect reaction. Now the patient is suspicious and hallucinated.

Pearl's paternal grandmother had mental disease, her father was high-strung, and her twin sister is "nervous" and worrisome.

Pearl Wilson is one of twin girls, born prematurely. They had to be wrapped in cotton wool and fed artificially for a long time. Pearl progressed normally through grammar school and the first year of high school, did clerical work for three years, and then for five years acted as bookkeeper and assistant to an office manager. She was well liked by her employers and did very satisfactory work. As is often the case, Pearl's personality was much like her twin sister's. She has always been "nervous", excitable, intense, and oversympathetic, "always trying to set the world right".

During the influenza epidemic, she became seriously ill. However, she would remain in bed for only two weeks and returned to the office while still in a depleted physical condition. She had to pay severe penalties for her indiscretion and suffered with badly infected throat and ears and abscessed teeth. Insomnia appeared, probably as an expression of pathological fatigue, but the patient succeeded in holding her position for eight months. The "pain" in her neck and head then became so severe that she had to go to bed for six weeks. During this time she was depressed and cried a great deal. When she returned to work and found that her former duties had been taken over by another person, she worried more than the occasion seemed to demand. Pearl could not reconcile herself and sought new employment. She did fairly well for eight months and then suddenly became "rigid and mute and could not hear or see".

Could Pearl Wilson have evaded mental disease under favorable or even average conditions? To her heredity and character traits a certain measure of responsibility must be conceded, but might she not have escaped if it had not been for the extraneous factor of the attack of influenza, with its serious sequels, which broke through her resistance?

Case 6. Grace Lord has apparently recovered from a psychosis which appeared when she was twenty-eight, lasted about twenty months, and during the greater part of its course was far from promising in its prognostic indications. Even at this late date several opinions may be more or less logically advanced. On the basis of fever, toxicity, and a high leucocytic count in the blood stream, one must think of a toxic psychosis; paranoid ideas, together with hallucinosis, catatonia, automatism, and a seemingly irrelevant affective reaction, bring schizophrenia strongly into the foreground; and finally unmistakable de-

pression and emotional excitation with psychomotor activity bring up the question of manic-depressive psychosis.¹

The family record is clear, with the exception of a maternal grandfather who developed "a mental disorder" in early adult life following enteric fever. He recovered in three months, returned to his work, and crowned his career by founding what is now a large and flourishing city. Grace was the second of seven children, all of whom are normal and probably above the average in their attainments.

Grace was normal and healthy as a baby and in childhood. She graduated from high school and supplemented her education by a year at normal school and a year at a business college. Until her marriage at twenty-four, she did well as a bookkeeper and clerk. The patient had certain personality shortcomings. She was somewhat timid and self-conscious, "dreamy", though not impractical, and inclined to be over-conscientious, a tendency that was not minimized by her bringing up in a religious atmosphere. Two and a half years after her marriage and something more than a year before the onset of the psychosis, a child was born in rather difficult instrumental labor.

Grace Lord's husband may be described as "sternly upright" with an "unerring" instinct of devotion to a personal sense of duty. This led him to support, not only his parents, but a ne'er-do-well brother, and as his earnings were quite small, it was, of course, necessary to bring all these people together in one household and to practice the most rigid economy. Perhaps the situation in which Mrs. Lord was placed is most eloquently described by the fact that her husband bought her only one dress during their married life and she had only a single pair of stockings. It is said that often she did not have enough to eat. It is probable that her brother-in-law several times attempted to make improper advances.

With Grace Lord's character make-up in mind, one may readily assert that there must have been a serious conflict between the natural desires of a young married woman to have a home of her own, nice clothing, and so forth and the self-sacrificial urgings of her over-conscientiousness. Perhaps some of this appeared in the psychotic self-accusation which later developed. In any event, she gradually became increasingly self-conscious and inadequate. She began to insist that she had committed many sins against her husband and thought that dictaphones were placed about the house and that she was being followed by detectives. Just after admission to the hospital, she excoriated her skin with a nail, printing the following: "Denied a chance to confess. I was to blame."

Was any one of the factors indicated sufficient to bring about a psychosis? Since the "toxicity" appeared definitely only after the psychosis was fairly well advanced, is it fair to assume that it alone was responsible? Is it not an over-assumption to state that Grace Lord's personality would surely have led to a psychosis, no matter what the circum-

¹ This patient has been readmitted with a recurrence. The psychotic content at present points to dementia praecox.

stances of her life had been? Did not life impose conditions—perhaps at a time when her physical reserve was lessened—which she could not consistently evade on account of her personality traits and which therefore could have in her case only the one issue of a gradual wearing away of “resistance” until contact with reality was broken?

Case 7. In view of Mary Cooper's history, it does not seem entirely unfair to say that mental disease in her case was merely *postponed* until she reached the age of thirty-six. Although at the present time there is a partial remission of some of the symptoms, there was never any doubt that we were dealing with an unfavorable dementia-praecox reaction. There is, or was, emotional inadequacy, mutism, catatonic episodes, and a striking regression in behavior.

The salient facts in Mary Cooper's family history are these: Her paternal grandmother was frail and “nervous” and died of tuberculosis at thirty-four; a paternal aunt was also frail and “was ill just like the patient for over a year”; her maternal grandfather died of tuberculosis at thirty-three; the father was eccentric, had an uncontrollable temper, and was probably mentally sick.

It was not surprising that Mary was an undersized baby, for, in addition to the ancestral shortcomings noted above, both her parents were undersized, and her father, who died of a stroke at fifty-three, probably also had tuberculosis. Mary herself never weighed more than seventy pounds. She was childish, “sweet-tempered”, and “kind-hearted”.

After completing grammar school and a commercial course, Mary was employed successively in listing alterations in the clothing department of a large store and in measuring ribbon bands for hats. At thirty-five she accidentally came into contact with an order of deaconesses, seemed greatly disappointed when she was not accepted as a member of the order, and began to ape their clothing and manner of living. Later she made several unsuccessful efforts to go abroad as a missionary. At thirty-six she bought a number of dolls and played with them alone in her room.

Would it not have been extremely difficult for Mary Cooper to remain in contact with reality? Is it not true that by reason of ancestral deficiencies she was totally unprepared both physically and mentally to play a part in the struggle for existence? Since she was practically defenseless, is it not correct to assume that even the slightest detrimental extraneous factor would have been sufficient to turn her back into unreality, from which, indeed, she had scarcely progressed?

Case 8. Helen Smith is now forty years old and has had mental disease for two years. She presents a somewhat atypical picture of

involutional depression. However, she exhibits considerable agitation, resistiveness, self-accusation, and bizarre somatic and nihilistic delusional formation, which on the whole are in keeping with the affective trend. Perhaps the self-accusation is the most outstanding symptom; for instance, "I have destroyed the world by lying"; "I've fooled everybody all the time". Often her self-accusation refers in symbolized form to masturbation.

Helen Smith is the product of a brilliant, though not always stable, line of ancestors. Side by side with college presidents and professors, are recorded several instances of relatives who were badly balanced or who had mental disease. The patient early in life gave promise of intellectual capacity. Soon after graduation from college, Helen became an assistant in an important library bureau and at the age of thirty-seven accepted the position of directress. Her leadership brought a greater measure of success. She had a cheerful, sympathetic, unselfish make-up, but worried easily. It is somewhat significant that her most marked trait was extreme conscientiousness.

The following factors stand out rather emphatically in her life history: At the age of twenty-two, she developed a chronic skin condition involving the face. It did not respond to treatment and was a constant source of irritation and worry to her. At twenty-six she saw her dearest friend kicked to death by a horse, and soon afterwards her mother died suddenly. At thirty she had influenza. She had probably for some years advanced apical abscesses and low-grade kidney inflammation. All these deterrent factors were episodes, mental and physical, that stood out from the background of a personality whose dominant element was *overconscientiousness*. This was the driving force that made it almost impossible for her to stop on the safe side. This was particularly evident in the few months that preceded the final break. The responsibility of being directress weighed very heavily upon her and she gave personal attention to innumerable details. A severe attack of bronchitis confined her to bed, but in a short time she insisted on resuming her duties. A period of worry and anxiety soon merged into pathological agitation, depression, and self-accusation.

Is it fair and conclusive to say that Helen Smith's mental disease was bequeathed by her ancestry? If her heredity contained the potentiality of insanity, is it not equally true that it held similar potent possibilities for normality and even brilliancy? What, then, caused the break from reality? Is it not possible that the overconscientiousness had at its roots a constant fear of falling short of highly placed traditional and personal ideals? What rôle did the physical factors play? It is perhaps not possible to decide whether or not they were at any time in the life history dynamic or merely secondary, but does it not seem reasonable at least to assume that as they became more and more serious, the pos-

sibility of combating the long strain of a tremendous over-conscientious energy diminished more and more?

Case 9. Elizabeth Taylor presents a classical textbook picture of a manic-depressive psychosis which began when the patient was thirty-nine and is now in its sixth year. Periods of manic excitement, in which there is extreme psychic and motor drive and emotional imbalance, are faithfully reproduced about six times each year and are succeeded in the intervals by markedly contrasting episodes of depression and retardation.

The patient came of sound stock—though her father is said by the patient to have had a violent temper—and had the environment and advantages afforded in the better type of average American household. She was quick-tempered, social, generous, impulsive, played hard and worked hard. At twenty-one she married a kind, considerate man and had an intimate and important rôle in furthering her husband's success in life.

In reviewing the life story of Mrs. Taylor, one comes at the age of thirty-one to a combination of physical factors which in the light of her psychotic history must be given considerable weight in considering the dynamic favoring circumstances of the psychosis. Coincident with an attack of scarlet fever, there was a miscarriage followed by infection. As permanent sequels there remained menstrual irregularity, uterine inflammation, high blood pressure, and nephritis. Mrs. Taylor carried the load of her physical liabilities for eight years before the definite psychosis appeared. One may reasonably conceive that during these eight years, there was an effort for physical, perhaps more narrowly endocrine, adjustment. The emphatic feature of her psychosis has been not so much the periodical and extreme rising and falling of the barometer of her mental life as the striking blood-pressure changes with which it is associated. For instance, during the depressed phase, the systolic reading is usually in the neighborhood of 180. It is apt to rise as the time for the excitement draws near and there is always a sharp jump on the first day of mania. A reading of 230 to 250 is usual during this period. As the depression appears, the process is reversed.

Could Elizabeth Taylor have remained normal if her physical health had not been subject to such an unusual strain? Do not the "physical" symptoms (blood pressure) of her psychosis make it not unnatural to assume that the tremendous onslaught (scarlet fever, abortion, infection, nephritis) on her physical resistance overthrew her metabolic (endocrine?) equilibrium and subsequently made possible the development of mental abnormality?

Case 10. Nancy Jones, aged forty-one, when studied in 1916 presented an involution depression. She showed a marked emotional distortion, and the psychotic behavior characteristics were in close accord with the profound apprehensive-depressive reaction. The agitation and

concomitant motor restlessness were of a very severe degree. She was self-accusatory and suicidal. In about five years she recovered.

The ancestry of this patient was not notably diseased. Mental abnormality in one paternal cousin and alcoholism in one brother does not fall far below the average, particularly since the parents were normal and there are three brothers and two sisters who are entirely well and socially productive.

Until the age of twenty-five, Nancy's life history is clear. Her lot was not cast in soft places. She had to work hard and had little time or opportunity for pleasure, but she had as an asset a cheerful, industrious, and unselfish disposition. All her employers regarded her highly, and she was a splendid cook and efficient housekeeper.

Unfortunately, at the age of twenty-five, Nancy married. There were five children. Two died in infancy and three are living at the ages of fourteen, nine, and two. During the first few months of their married life, the husband revealed himself as an habitual drunkard. He frequently struck and kicked the patient, denied her the necessary money for household expenses, often put her out of the house at night, threatening to kill her and commit suicide (the latter threat he finally carried out in January, 1917), and was always disagreeable and profane. Probably Nancy should not have endured fifteen years of such abuse and ill-treatment, but she was rather helpless as to ways and means and furthermore was devoted to her children. In November, 1915, Nancy's menstrual periods ceased (menopause?) and she confided to her husband her belief that she was pregnant. Thereupon he became more vicious and abusive than ever before. Nancy became depressed, had long crying spells and severe headaches, and lost much weight. She spoke vaguely of having committed a terrible sin. There followed a period of prayer lasting a few days, and a single day during which she was manic, singing and dancing, and then appeared the more definite aspects of the psychosis.

Is it not reasonable to assert that Nancy Jones' family history and her life record for its first two and a half decades prove that her chances of getting through life without mental disease were better than or at least as good as the average individual's? Do not the fifteen years during which she endured the destructive assaults of her environment prove that she had a strong "resistance"? Was it not the unusual culmination and combination of adverse circumstances (mental torment, ill-health, menopause) that determined the final break?

Case 11. Sarah Burns became acutely ill at the age of forty-five. The outstanding symptomatic content of the psychosis—restlessness, apprehension, self-accusation with entire adequate depression—made it comparatively simple to classify as an involuntional melancholia. After a period of eight months, Mrs. Burns made a satisfactory adjustment and has been well for almost a year.

Mrs. Burns comes of sound Irish-Catholic ancestry. She had only a

minimum amount of public-school education and then earned her living in a glove factory and finally for about ten years was a faithful attendant in a hospital for mental diseases. The family felt that Sarah had an unfortunate disposition. She was "nervous", pessimistic, worrisome, superstitious, apprehensive, and overconscientious. At the age of thirty-one she married a man of her own station in life who treated her well, and they were congenial and happy.

Whether one traces Mrs. Burns' pre-psychotic history forward step by step or views it retrospectively from the vantage point of the psychotic content, there are in either case two noteworthy factors. The first is a distinct tendency to thyroid toxicity. At the age of thirty-three, following childbirth, there appeared a fullness of the thyroid gland with exophthalmos and fatigue, restlessness, and mental irritability. At thirty-nine, thyroidectomy was deemed necessary, but at forty-two the goiter again became noticeable and at the beginning of the psychosis the phenomena of Graves' disease were pronounced. The second factor is a self-induced abortion which Mrs. Burns performed at the age of thirty-one—*fourteen years before the onset of the mental disease*. The psychosis followed almost immediately upon the death of a niece from puerperal septicemia due to attempted abortion. It is evident from the patient's earlier productions that her consciousness was at once flooded with the perhaps partially suppressed recollections of her own experience. The niece "appeared to her in a vision"; the family blamed the patient for her death; her soul was "to be damned to hell"; and the like. The patient's retrospection during convalescence made clear many less obvious reactions.

While one may be fairly clear as to the conditioning factors of the psychosis, the question of their relationship and precedence is less obvious. In the first place, were Mrs. Burns' personality traits the result of an early thyroid dysfunction or was this latter the sequence of her emotional imbalance? At any rate, is it not true that the condition which was present at the age of thirty-three meant that year by year her ability to meet an emotional crisis became somewhat lessened? Is it not fair to assume that this emotional crisis finally appeared in the shape of the death of a favorite niece from self-induced abortion? Certain of the elements of the precipitating situation seem largely accidental, principally the fact that Mrs. Burns had to meet this crisis while she was at the beginning of the climacteric and that it was so intimately connected with a previous highly colored emotional experience (her own abortion) which must have been all the more significant on account of her religious beliefs. Would not one be justified in the opinion that if the path had not been prepared by emotional "weakness", either due to the endocrine disease or

determining it, or if the psychic insult had not occurred or perhaps had not made its appearance at such an unfavorable time, the final step away from reality would not have been taken?

Case 12. Catherine Louis is at the present time in a state hospital. Her psychosis began about eighteen months ago at the age of forty-eight. There is a strong depressed-apprehensive affect closely paralleled by the following behavior characteristics: tremendous motor restlessness, moaning, resistiveness, blind violence directed against her immediate environment, profanity, and untidiness. She frequently says, "I want my body back. This ain't me."

The patient is one of seven siblings, and the family is of sturdy German immigrant stock. A sister had a "nervous" spell at fifty-five, but otherwise the record is clear. No one ever thought that Catherine was "nervous". It is agreed that she was the "most lively" and the "social one" of the family. From seven to sixteen she made the ordinary amount of progress in school, and from seventeen to thirty-four she was efficient and successful as cashier in a large department store. At thirty-four Catherine's first love affair culminated in marriage. "Her devotion to her husband was very great. They were inseparable and never without each other. He was a cut-glass worker, and two years after their marriage, he began to have lung trouble, which was attributed to his occupation. He then developed tuberculosis and for at least ten years the patient's life was one of anxiety, strain, and constant worry."

Immediately after her husband's death, Mrs. Louis became depressed and agitated, talked incessantly about her husband, and asked every one if it were not possible that the doctors were wrong when they had told her that nothing could be done for him.

Physically Mrs. Louis was strong and well in girlhood. It is noteworthy that for the ten years corresponding to the decade of emotional stress, there was intermittent and distinct thyroid enlargement. At intervals both before and during the psychosis, the gland became extremely prominent and was associated with other thyrotoxic manifestations.

Is it not probable that the ten-year period of mental and physical strain gradually wore away Mrs. Louis' "resistance"? In view of her relatively sound ancestry and normal make-up, is it not reasonable to suppose that the combination of detrimental factors (long period of mental strain, menopause, endocrine dysfunction) were instrumental in breaking the contact with reality? Is it not likely that the endocrine dysfunction was effected through the agency of affective strain, perhaps the more easily because there already existed a point of weakness in the endocrine balance?

Case 13. Sophia Bronson did not develop mental disease until her fifty-third year. If she were twenty or even ten years younger, she would hardly escape the diagnosis of dementia praecox, on the basis of a paranoid trend well supported by hallucinosis. However, the thread of consistent depressive affect has never been broken. A good descriptive term would be involuntional paranoid psychosis.

The family history is clear of potential sources of danger.

Mrs. Bronson was a healthy, normal child, the fourth in a family of five. Her early life was not eventful. She completed grammar school and lived at home until her marriage at the age of twenty. During the first two decades of her married life, she was contented—"never got cross or excited; always calm and quiet". She has two sons. The first was born two years after marriage and is a dwarf and hunchback, but possessed of normal mental equipment. When Mrs. Bronson was forty years old, she discovered that her husband was infatuated with another woman. Although he persistently annoyed her in order to gain her consent to divorce proceedings, she steadfastly refused. Even when he decided to live openly with the second woman, she still held to her determination and supplemented the uncertain support received from her husband (he had failed in business) by keeping house for her youngest son. It is somewhat difficult to understand just why Mrs. Bronson refused to take what seemed to be the only practical step under the circumstances and to coöperate in a legal separation. It is possible that she felt it was rather late in life to attempt a readjustment and hoped against hope that eventually the tangle would be straightened out.

Gradually her disposition changed and her even temperament gave way before worry and sadness. However, she was able to keep her contact with reality for almost thirteen years, when she suddenly became excited, apprehensive, and suspicious, said that her husband was sending people to annoy her, and was actively hallucinated. Her climacteric began at about the age of forty-eight.

Is it not true that in view of her normal ancestry and her clear record during childhood, adolescence, and maturity, including twenty years of married life, the supposition would be that Mrs. Bronson would pass through life without breaking contact with reality—in other words, with perfect sanity? Do not the thirteen years during which she faced a difficult situation indicate that her "resistance" was strong? Is it not possible that she might have met and come through the situation safely if it had appeared during the third or fourth decade of her life, when her powers of resistance were on the increase, instead of at the beginning of the fifth decade when they were beginning to wane and added detrimental factors—as, for instance, the menopause—would have to be considered?

Case 14. Carrie Brantwood, at the age of fifty-four, is in the fifth month of an involutional melancholia.¹ The initial distinct apprehensive affective reaction is at present somewhat obscured, as most of its motor and ideational concomitants are hidden by the curtain of a stupor, but it is evident from the facial expression and the occasional perplexed productions that the emotional life has not been lost.

Carrie Brantwood was born in a small Pennsylvania village. She has two younger brothers, both of whom are married and successful in business. On rather slim and somewhat biased evidence, it is said that the maternal grandfather was a reprobate and that the patient's mother is excitable, stubborn, and opinionated.

Until her marriage at the age of twenty-six, the patient's life was typical of the average small American village. From six to eighteen she attended the village schools and was an average pupil; from eighteen to twenty-six she worked at dressmaking. From the several accounts we may picture Carrie Brantwood at the beginning of her married life as a happy, sociable, rather sensitive, but essentially normal young woman. A few years before the onset of the psychosis, she is described as morose, silent, almost "seclusive", "afraid to talk", "keeps away from people". What brought about such a regression of personality? In the first place, life was made somewhat difficult for the Brantwoods by obstacles that, while trying, were certainly not in any way unusual. The husband was a minister and later taught in a small college, and as he was generally in poor health, the financial outlook was always precarious. However, Mrs. Brantwood was neither extravagant nor selfish. She cheerfully made the best of conditions and took an active interest in her husband's church work and nursed him when he was ill. She had one child, a daughter, now twenty-seven years old. The climacteric began four years ago.

Perhaps one can best express the *avoidable* handicaps to which the patient was subjected by quoting from the records: "The husband has a single-track mind and is self-centered and inconsiderate. His wife has suffered from his neglect for many years. He often criticizes her and does not hesitate to correct and humiliate her in public. He is a 'crank' about food, often lives on breakfast food, and if something did not suit him, he would throw it across the room. He did not permit her to handle money and bought the food, the furniture, and even his wife's clothing. 'When she became ill, he neglected her, and she was found by a relative alone, seriously undernourished and without medical attention.' It was then that Mrs. Brantwood began to repeat, 'I sat alone, I sat alone,' and soon after became agitated and apprehensive, believed that she had destroyed the world, and could hear the coals being put on the fire which was to consume her."

Is it possible to overlook the tremendously serious detrimental factors with which Mrs. Brantwood had to contend in any attempt to evaluate the genesis of her psychosis? Would it not be somewhat questionable to seek in her ancestry the entire explanation, when a more rational one is at hand

¹ After several years, the condition is seemingly chronic.

in her own life? Did not the long struggle against a situation that was not only impossible, but unescapable create a vicious circle, which had so reduced her resistance at all points that when she came to a critical period, a psychosis was the natural expectation?

Case 15. Annie Blank passed through the critical phase of her psychosis so many years ago (the onset was in 1906 at the age of sixty-two) that it is difficult to assign her even to one of the unsatisfactory diagnostic niches which are provided in psychiatric nomenclature. The condition that she presents to-day has been maintained at the same level for more than a decade. Probably the mild depressive affective reaction is in alignment with quiet, inactive, unresponsive, but not unco-operative behavior, so that it is difficult to postulate a deteriorating psychosis.

Annie Blank should have found an almost inexhaustible reserve of mental strength in her ancestry. There is no discernible trace of abnormality in the family history. One may, perhaps, find a strong suggestion of the truth of this statement in the fact that her seven brothers were all intelligent, capable, and successful in a diversity of occupations.

One may look in vain for definitely dangerous trends in the first two decades of Annie Blank's life history. She was social, rather meek, gentle, and unselfish. After having received the equivalent of a college education, she married at the age of eighteen. She bore eleven children, six sons and five daughters, but the following quotation from the records shows that her life was far from happy: "Soon after her marriage her husband began to be overbearing in his manner, neglected her, and made it unpleasant for her friends. He was irresponsible, did not provide for his family, abused the patient and the children and often threatened to kill them, was a chronic alcoholic and immoral. The patient was lonely and unhappy and in a constant state of terror. Later, after the climax of her life had passed, there were more or less half-hearted attempts to live with her grown children at their solicitation, but always her husband was able to frighten her into returning home."

Just prior to the onset of the psychosis, there was a struggle with her husband, and the patient's arm was broken. Soon afterward she became noisy, violent, and fearful of being killed, and refused food because "it was poisoned". Even at the height of the psychosis, it is evident that the patient regarded the hospital as a haven, for she was constantly apprehensive lest she be taken away.

Even disregarding the favorable heredity, do not the last four normal decades (twenty to sixty) of Mrs. Blank's life prove that she used all of her reserve equipment in "resisting" and combating overwhelming odds? Is it not likely that this resistance was eventually worn so thin by long contact with an unfavorable environment that the final break could have been accomplished by any trivial incident?

ANALYSIS OF CASES

Before attempting an analysis of the factors that in these fifteen patients seemed to undermine the defensive strength and make inevitable the translation of reality or sanity into unreality or insanity, it may be well to state several reservations. In the first place, it is exceedingly likely that only outstanding points came into the retrospective field of vision and many important facts may have been omitted. Again, it should be repeated that the study of these cases from the "long-section" viewpoint is not at all exclusive of possible directly specific agents, though thus far in psychiatry no etiologic theory of the "this or nothing" type has deserved advancement beyond the theoretical stage. Finally, the objection that other individuals might be placed in exactly similar circumstances to those related and still escape mental disease should be anticipated. This is, of course, not to be denied, but it does not interfere with or invalidate the idea that is expressed. Briefly, this is that in each human being there is an utilizable amount of resistance, no more and no less, and if detrimental influences, whatever be their nature—hereditary, physical, or psychic—overbalance this defense, the connection with reality ceases. It is somewhat doubtful if the hypothetical supernormal being who can successfully resist every combination of detrimental onslaughts directed against his somatic and mental well-being has ever or will ever exist. In other words, it is probably as true in psychiatry as it is in internal medicine that the power to withstand is limited and may be overtopped by a combination of adverse conditions.

In the following table, the prominent available determining life incidents in the patients studied are enumerated. They are primarily and arbitrarily graded alphabetically according to the order of their importance. Sometimes they include both physical and psychogenic elements and then they are listed under both headings. A dash indicates absence or relative insignificance.

	HEREDITY	PERSONALITY	ORGANIC	PSYCHIC
<i>Mary Brown—Case 1.</i>	Paternal grandfather criminal, father epileptic, mother and maternal uncle insane. (A)	Self-willed, dramatic, affected, sensitive, and seclusive. (B)	Unfavorable environment from early childhood. (C)	
<i>Virginia Green—Case 2.</i>	Maternal grandfather senile dement, maternal uncle insane, maternal aunt peculiar. (D)	Sensitive, "spoiled". (C)	Septic infection. (B)	Illegitimate pregnancy, criminal operation. (A)
<i>Frances White—Case 3.</i>	_____	_____	Influenza and encephalitis (?). (A)	Love affair (?). (B)
<i>Yetta Cohn—Case 4.</i>	_____	Sensitive, worrisome, and overconscientious. (B)	Dysmenorrhea, chronic digestive disturbance, intense headache, surgical operations, influenza, pneumonia, pleurisy, and fatigue. (A)	Death of aunt and brother. (C)
<i>Pearl Wilson—Case 5.</i>	Paternal grandmother insane, father "high-strung". (D)	"Nervous", excitable, and intense. (B)	Influenza with sequelae, infected throat and ears, abscessed teeth, and fatigue. (A)	Worry about work. (C)
<i>Grace Lord—Case 6.</i>	Paternal grandfather post-typhoidal psychosis. (D)	Timid, "dreamy", overconscientious, idealistic. (B)	Instrumental labor, poor health. (C)	Unhappy conditions of domestic life, attempted sexual assault. (A)
<i>Mary Cooper—Case 7.</i>	Paternal grandmother and father insane, both parents organically inferior. (A)	"Childish" and defective and inferior physically. (B)	_____	_____
<i>Helen Smith—Case 8.</i>	Unstable, often brilliant, and successful. (C)	Worrisome, overconscientious. Sense of inferiority. (A)	Chronic skin condition of the face, influenza, apical abscesses, kidney inflammation, bronchitis. (B)	Sudden death of mother and friend. (D)

	HEREDITY	PERSONALITY	ORGANIC	PSYCHIC
<i>Elizabeth Taylor—Case 9.</i>	Father violent-tempered. (C)	Quick-tempered, impulsive. (B)	Scarlet fever, miscarriage, septic infection, nephritis, high blood pressure, endocrine disorder (†). (A)	—
<i>Nancy Jones—Case 10.</i>	Paternal cousin insane. (C)	—	Fatigue, undernourishment, ill health. (B) Climacteric	Constant worry and fear. (A)
<i>Sarah Burns—Case 11.</i>	—	“Nervous”, pessimistic, worrisome, superstitious, apprehensive, overconscientious. (C) †	Endocrine (thyroid) overbalance. (B) † Climacteric	Mental conflict arising from self-induced abortion of a niece. (A) †
<i>Catherine Louis—Case 12.</i>	—	—	Endocrine (thyroid) toxicity, fatigue. (B) †	Anxiety, strain, and worry, over husband's illness. (A) †
<i>Sophia Bronson—Case 13.</i>	—	—	— Climacteric	Husband unfaithful. (A)
<i>Carrie Brantwood—Case 14.</i>	Paternal grandfather reprobate (†). Mother excitable and stubborn. (C)	—	Sick, undernourished, and fatigued. (B)	Constant worry about unhappy marriage. (A)
<i>Annie Blank—Case 15.</i>	—	—	—	Worry and fear due to alcoholic, immoral, abusive, and irresponsible husband. (A)

Although the number of patients studied is far too limited to possess any statistical value, yet it may be interesting to attempt a brief summary. In two cases—Mary Brown and Mary Cooper—the influence of heredity was overwhelming, which is tantamount to saying that practically from birth the amount of resistance that the patient was able to interpose between herself and ordinary environmental exigencies was negligible. In four instances—Virginia Green, Pearl Wilson, Helen Smith, and possibly Carrie Brantwood—ancestral unsoundness perhaps made the development of mental disease less difficult, but it is doubtful if alone it would have been significant. In three cases—Grace Lord, Elizabeth Taylor, and Nancy Jones—it was easily overshadowed by other features, and in the case of the remaining six individuals, the family stock was probably somewhat better than the average.

Personality may be regarded as the eventual outcome of inherited tendencies plus the individual's reaction to environmental advantages and disadvantages, and it acquires tremendous importance either as a liability or an asset in meeting the problems of living. In six of our group—Frances White, Nancy Jones, Catherine Louis, Sophia Bronson, Carrie Brantwood, and Annie Blank—the "make-up" was definitely a helpful one; in Helen Smith it seemed to act as a driving force which, when its effectiveness was blocked by insurmountable obstacles, largely determined the final issue between sanity and mental disease; in at least three patients—Yetta Cohn, Pearl Wilson, and Grace Lord—and doubtfully in another—Sarah Burns—it appeared to have a strong regressive pull.

The weakening of resistance by organic determinants was marked in Frances White, Yetta Cohn, Pearl Wilson, and Elizabeth Taylor, and in Virginia Green, Helen Smith, Nancy Jones, Sarah Burns, Catherine Louis, and Carrie Brantwood it was very prominent.

The so-called psychic insult stood out in eight cases—Virginia Green, Grace Lord, Nancy Jones, Sarah Burns, Catherine Louis, Sophia Bronson, Carrie Brantwood, and Annie Blank.

In order to estimate the psychosis as a total and lifelong

reaction, the association of the several motivating elements of the history and their relation in point of time as they appear on the surface should be scrutinized. In Mary Brown a pathological personality was the natural outgrowth of a grossly defective inheritance, and the final step into mental unreality was easily taken at the age of nineteen. In Virginia Green the mental crisis induced by the guilty secret knowledge of an illegitimate pregnancy plus septic infection following a criminal operation, which together seemed to be immediately dynamic, was brought about in a few months, but the character make-up on which they reacted so destructively was the outgrowth of a deficient environment during girlhood and early adult life. In Frances White the transition to unreality was acute—corresponding to an overwhelming infection. In Yetta Cohn there was the irreconcilable clash between over-conscientious idealism, with a desire to accomplish, and increasing physical limitations, which covered a period of at least seven years. In Pearl Wilson the physical and mental strain was moderately acute, but the none too resistant temperament was years in the making and its development was presumably favored by the unhealthy ancestral strain. In Grace Lord there was an unsolvable conflict, lasting more than three years, between adverse conditions imposed by an unhappy domestic life and natural longings, with an innate and long established personal inability to force a conclusion. In Mary Cooper it is not unlikely that the psychosis was largely determined before the patient was born. In Helen Smith the irrepressible urge of personal and traditional ambition sought to satisfy a sense of inferiority and gradually, over a period of at least sixteen years, this unavoidable task became more and more difficult, due to the accentuation of somatic and psychic stresses. In Elizabeth Taylor the physical machinery was irretrievably damaged at the age of thirty-one, and nine years later the mental health broke. In Nancy Jones the resistance was continuously assaulted for fifteen years. In Sarah Burns, with a background of abnormal character marks, a vicious organic-psychic circle was established at thirty-one and reached its breaking point fourteen years later. In Catherine Louis there was a decade of psychogenic-somatic strain. In Sophia Bronson

there were thirteen years of struggling against a hopeless environment. Carrie Brantwood lived for many years in inimical and uncompensated surroundings; and Annie Blank survived mentally forty-four years in a world filled for her with destructive forces. Thus, in only one instance (Frances White) may we be dealing with a possible single etiologic agent; the remainder of the psychoses may be tentatively and most instructively regarded as lifelong non-specific reactions, which may be said to have been occasioned by a multiplicity of non-specific causes.

Incidentally, the diagnostic-prognostic indications in several of these patients are worth mentioning. Virginia Green recovered apparently in the face of a malignant psychosis, and in Pearl Wilson the early outlook was promising, but subsequently had to be reversed. Perhaps the former had a slight advantage from the standpoint of heredity; in any event, her personality traits were less unfavorable and certainly the conditions that life imposed before and that might be looked for after the psychosis were distinctly less difficult and there were fewer obstacles in the way of a return to normality. In Elizabeth Taylor and Catherine Louis the mental disease became chronic, although from the standpoint of strict clinical psychiatry, they had rather favorable affective reactions. In both instances it seems not unlikely that the emotional upheaval and an endocrine imbalance are closely related and continue to set each other in motion in a pathological and more or less automatic manner. In Carrie Brantwood and Annie Blank we are probably dealing with non-deteriorating states. They seemed to have been resultant upon a long struggle with adverse conditions and the environmental situations engendered seemingly still obtain even at this late date.

CONCLUSION

What are the advantages and disadvantages of thinking of mental disease in tentative terms of non-specificity? The primary objection that independent lines of investigation with a single objective might be hindered is hardly valid. In our fifteen cases defective heredity, personality shortcomings, and physical and psychic stresses were brought into

the field of inquiry. According to the inclination of the individual neuropsychiatrist, any one of these may be emphasized. There is only the reservation that others should not be ignored. For instance, in Helen Smith the attention might presumably be closely focused on the apical abscesses, and in Sarah Burns on the repression or partial repression and conflicts, but a blind spot should not be developed for other plus and minus resistance quantities whether they be traceable to heredity, personality, somatic, or psychogenic factors. At most, a healthy check is placed on the tendency to regard every hypothesis as an incontrovertible fact. Thus the door of research is left open to its widest possible extent.

The non-specific conception demands a painstaking "long-section" rather than a "cross-section" survey. The advantages to therapy should be obvious. One is left with a number of more or less measurable quantities, and the approach is at once broad and comprehensive. The removal of infected teeth, tonsils, or other demonstrable pathology need not and should not exclude legitimate psychotherapeutic procedures in the same or in another case, and vice versa. In the present state of our knowledge, this is the only fair treatment method for the patient.

For prophylaxis and mental hygiene the gain is even more pronounced. Once we know, even if it be only approximately, the various conditions on the basis of which a psychosis appears to develop, we can begin to devise protective measures and formulæ to be utilized in an attempt to decrease the percentage of mental disease. Even heredity may not be dismissed as "a fixed quantity in the equation". A better understanding of its workings may lead to the evolution of valuable safeguards with both an individual and a social application. Surely the personality is not rigidly predestined. Is it not thinkable that a potential psychosis may often be turned into safe channels after we have had enough experience to point out certain common and avoidable personally injurious and environmental shortcomings? Certainly a more exhaustive analysis of somatic and psychic insults would not be fruitless. The question of fatigue alone and its safe limitations is of far-reaching psychiatric import. The subject of the ultimate relationship between

somatic processes and harmful affective states has scarcely been touched. Even a loose measure of the deteriorating effect of abrupt and critical or chronic and accumulative emotional strains on the mental health might provide certain wise precautions—at least comparable, for instance, in importance to the better understood forethoughts of sanitation and hygiene in respect to public health. These and similar benefits, both to the individual patient and to psychiatry, can scarcely accrue from any hypothesis that restricts itself to a single point of view.

CONCERNING THE RELATIONSHIP BETWEEN RELIGIOUS EXPERIENCE AND MENTAL DISORDERS

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WHILE looking over the books in a psychiatric library some months ago, I was surprised—in fact, startled—to find a four-volume treatise entitled *The Insanity of Jesus (La Folie de Jésus)* by a professor of psychiatry in the University of Paris. It had never before occurred to me that any man could take such a serious view of the mental condition of Jesus as to use up four sizeable volumes upon it, much less that there was sufficient evidence in regard to it to occupy so much space. A glance at the contents told me at once more about the writer than it did about Jesus. He is entirely hostile to religion in any form. Not only was Jesus a degenerate paranoiac and a weakling, but Paul, Augustine, Ezekiel, and other religious geniuses were all afflicted with “*paranoia théomanique*”, and if they were living to-day, would very properly be confined in hospitals for mental disease. The author is intemperate and violent in his tone, he is lacking in any sense of value or proportion, and he is wholly uncritical in his use of sources. He is not, therefore, to be taken over-seriously.

This book has, however, drawn my attention to a problem of great importance concerning which I find a growing body of literature. Not only Dr. Binet-Sanglé, but also a Dr. Hirsch and a Dr. Lomer have made psychiatric studies of Jesus and contend that he was a paranoiac. A Danish authority named Rasmussen is of the opinion that he was an epileptic. Meanwhile psychiatric studies of other great religious geniuses are appearing by the score, not merely from the pens of over-rash Freudians, but also from adherents of the more orthodox schools. The theologian, on the other hand, if he is not serenely oblivious to these psychiatric

ventures, is very indignant at what he considers assaults upon the heroes of the faith. He is even apt to resent Professor James' sympathetic *Varieties of the Religious Experience*, because it dares to suggest that there is a connection between experiences that to him are sacred and of supreme value and experiences that have in them many elements of the morbid and pathological.

The suggestion that I would offer is that the psychiatrist is right in drawing attention to the common characteristics in the experiences of individuals whom we regard as religious geniuses and those of patients in our hospital for mental disease, but that he has failed to recognize with sufficient clearness the sharp contrast and the real line of demarcation between them. I would offer the further suggestion that the common characteristics are due to certain common causative factors and that therefore study of the one type in the light of the other may be of real value in solving the problem of effective treatment for those who are suffering from mental difficulties, both in their incipient and in their more developed stages.

In making this suggestion I am of course assuming that many mental disorders are of mental rather than physical origin, and that in such cases a conflict is probably at the root of the difficulty. Such conflicts, as I view them, are in themselves neither good nor bad. They often represent an intermediate stage through which certain individuals must pass if they are ever to reach a level of development at which their interests, instead of being devoted exclusively to baseball and jazz music and matters that savor of the pornographic, or perhaps being bound up in some hope that cannot be realized, become genuinely attached to things that have enduring value both for the individuals themselves and for the race. Such conflicts are found in all those experiences which the religious worker calls conversions. Not infrequently such conversion experiences are accompanied by voices and visions and other automatisms which the psychiatrist regards as pathological. But the conversion experience has this characteristic: it results or tends to result in a reintegration of the personality around what the individual regards as the purpose of life. The conversion experience, in other words, tends to bring the

individual into harmony with himself and with his environment.

But conflicts do not always result happily. Sometimes they result in defeat or demoralization or more or less permanent cleavage. This, as I see it, is the explanation of some psychoses. But between these two end states of clear-cut victory and unification and clear-cut defeat and demoralization there may also be a condition of acute conflict or of unstable equilibrium. This unstable equilibrium I regard as the explanation of many cases of "psychoneurosis" and perhaps of some "manic-depressive" types of mental trouble.

According to this view, the significant thing about Jesus or Paul or Augustine is not the presence or absence of certain pathological phenomena, which may have been incidental to some severe conflict through which they had passed and the consequent sensitizing of their minds; the significant thing is the end attained in terms of character and social helpfulness, in the breadth of their sympathies, in the unification of their interests around a great and socially useful purpose, and in the serenity and beauty and strength of the resulting personality. It is, therefore, of the greatest importance, in the treatment of any case of mental difficulty, to take into account the character of the conflicting forces and the general direction in which the personality is tending. Medical workers are, I think, beginning to see this, and there is significance in the fact that specialists in mental disorders are entering the domain of philosophy and ethics and religion, and are speaking with an authority that the philosopher and the theologian, who start with abstract ideas or traditional dogmas, no longer possess. The physician, as a result of his empirical method and his careful, systematic study of living men and women, has thus in very truth become a physician of souls, while the traditional "physician of souls", clinging to his traditional methods, has become merely the custodian of the faith.

This raises the question of the relationship between the medical and the religious worker and the need of coöperation between them. The view may be taken that the medical worker has the field and that the religious worker has now become unnecessary so far as treatment of mental disorders

is concerned. My own view is that the religious worker, with all his limitations and with his waning influence, has yet in his keeping three things that are of fundamental importance in dealing with this problem:

1. A message with regard to the ultimate realities of life that has brought comfort and hope and strength to many a sufferer. Inasmuch as a sense of being out of adjustment with what they conceive to be the purpose of life is characteristic of many sufferers from mental disorders, the guidance of a wise religious teacher should be of great value.

2. An effective means of reëducation through suggestion in prayer. The religious man who is true to the teachings of Christianity has all that M. Coué can give him and much more.

3. A group of socially minded people of whom the religious worker is the chosen leader and through whom he can greatly multiply his own effectiveness. Such a group can be utilized to provide a wholesome environment for the man in distress.

The task of most religious workers is and must always be to deal with these problems before they reach the advanced or acute stages that we meet with in the hospital for mental disease. But to be able to do this effectively, religious workers must have a far better understanding of such problems than they have to-day. To this end there should be specialists in this field who would have much the same relationship to the average pastor that the medical specialist has had to the old-time general practitioner. Such specialists, working in coöperation with medical workers, can bring to bear upon certain acute and difficult cases such insight and experience as the group of religious workers may possess. They can also serve as "liaison officers" between medical workers in psychiatry, with their already advanced knowledge, and religious workers at large. Such a plan, by using machinery already in existence, could without additional expense to the state greatly increase the effectiveness of psychiatric work, not merely in the way of prevention, but in the matter of more sympathetic oversight of discharged patients. I do not mean by this to imply that the medical profession does not already possess facilities for this work, but I do say that the problem is one of such magnitude that the church can help. This applies not merely to local communities, but to hospitals as

well. Those who have had any experience in hospitals for mental disease know that, except in the expensive private sanatoria, the physicians are so busy with their routine duties that conferences with the patients, even though recognized as desirable, are almost out of the question.

In suggesting this plan I am under no illusion as to the present equipment of the average pastor for such work. His academic preparation has not included the consideration of such problems. He finds himself quite at a loss when he meets them in actual life. The one chief piece of machinery that the Protestant Church has worked out for dealing with the man who is sick of soul is the "revival meeting", and it is an open question whether this method in practice does not do almost as much harm as good. What I do see is the potential power of the church to contribute to the solution of this problem. I also see the influence upon the church of a new method which will lead the trained religious worker to study the human personality and the forces that operate upon it as medical workers have studied the human body and its behavior.

SOME COMMUNITY ASPECTS OF FEEBLEMINDEDNESS*

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IN February 1922, a subcommittee of the Charity Organization Society of New York City was formed for the purpose of studying the problem of mental defect among the families under the society's care. It had been found that from 12 to 15 per cent of the entire case load of the society consisted of diagnosed cases of mental disease and defect. The addition of undiagnosed, but suspected cases would bring the total to about 25 per cent of the annual case load. This would not include the innumerable slighter "mind twists" familiar to us all.

The committee was composed of Miss Sarah Dean, Chairman, and member of the Committee on Coöperation and District Work; Miss J. C. Colcord, District Superintendent; Miss Helen Large, Secretary of Gramercy District; Dr. Clarence Cheney, of the Utica State Hospital; Dr. Samuel Heckman, of the City College of New York; Dr. Frankwood E. Williams, of The National Committee for Mental Hygiene; Miss Gertrude Scott, of the Jewish Board of Guardians; Mrs. Mary Paddon, Commissioner of the State Probation Commission; and the writer.

This study was undertaken chiefly because of the growing feeling among the staff workers of the society that feeble-mindedness in the family group constitutes to-day a problem more disintegrating to family and social welfare, more baffling to progressive social case-work, than almost any other single maladjustment. It is in keeping with the spirit of our age that

* EDITOR'S NOTE: In view of the somewhat discouraging data presented in this paper, it may be well to state that Miss Hamilton is preparing an article on community supervision of the feeble-minded, which will deal with some of the more hopeful aspects of the problem. This second paper will be published in an early number of MENTAL HYGIENE.

case-workers should try to make a more scientific approach to those world-old enemies of social progress—venereal disease, chronic poverty, chronic unemployment, desertion, mental disorders, and the like. Family situations that have defied the most thoughtful, the most scientific, and the most thorough individual treatment that our present skill can command still confront case-workers, and some of these situations are now being referred to special committees and to special research workers for more thoughtful investigation, more careful evaluation, and fresh interpretation.

Many facts long familiar to social workers have lain buried waiting for the spade and chisel, like the tomb of King Tutankhamen. There is this difference—the treasures of that old Egyptian king will go into some museum, but the facts of social science, unearthed, compared, and correlated, may be fitted into a fresh and vital program for the betterment of the community.

The following study is part of a long report, submitted to the above-named committee, on various social aspects of feeble-mindedness in New York City. The field study was made in the summer of 1922 to establish certain facts with regard to the social adjustments that had been made by an unselected group of mental defectives known to the Charity Organization Society.

Case-workers have long since abandoned the *clichés* "worthy" and "unworthy" and are concerning themselves with the conditioning factors that make families dependent or antisocial. More and more they are realizing how greatly feeble-mindedness contributes to the difficulties of extensive relief work on the one hand and intensive case-work on the other. Under existing conditions, relief can rarely be given so as to react to the permanent benefit of the individual, and the most thoughtful case-work proves in some situations abortive. As Dr. Fernald says in his *What is Practicable in the Way of Prevention of Mental Defect*¹:

"Some of our methods of care have so propped up the defective and relieved him of burdens that he has been enabled the more easily to live and propagate his kind. In fact, with

¹ Boston: Massachusetts Society for Mental Hygiene, 1916. Publication No. 6.

the very highest motives, modern philanthropic efforts often tend to foster and increase the growth of defect in the community. . . . The one effective way to diminish the number of the feeble-minded in future generations is to prevent the birth of those who would transmit feeble-mindedness to their descendants."

The Charity Organization Society naturally cannot employ this "one effective method", and year by year is called upon to alleviate a situation that often does not permit of alleviation, and to shoulder responsibilities that properly belong to the city and to the state—not that the city and state are unaware of their responsibilities, but everywhere the matter is being touched only in spots. There are children now in the grades who should be in special classes, and children in special classes who should be in institutions, and thousands of irresponsible adults without intelligent supervision of any kind. Case-workers are asking what are they to do about a feeble-minded child at a standstill in school whose school principal does not believe in ungraded work. Many of the public schools have not—and so far as we know, none of the parochial schools has—ungraded classes. What are case-workers to do with a promiscuous feeble-minded woman of child-bearing age who eludes supervision or institutional care? What are they to do with the affectionate, moral, but utterly disastrous feeble-minded wife and mother who can lawfully bring up eight or ten children under conditions that should have been intolerable in the Middle Ages? What are they to do with a good-looking, high-grade mentally defective father who is, as the phrase goes, "doing no harm", but whose neglected children are furnishing some of the behavior problems, dependents, and delinquents of their generation? What are they to do with a feeble-minded, epileptic child whose brothers and sisters are kept out of school in order to care for him? And while some experts say, "Why, these people should be committed", and others say, "Why, they should be supervised in the community", case-workers in a city like New York find that often, as a matter of fact, neither course is practicable.

Miss Mabel Matthews, head worker of the Massachusetts School for the Feeble-minded, in MENTAL HYGIENE for April

1922, has given us a very interesting and encouraging study of one hundred institutionally trained male defectives in the community under supervision. These boys, who had been paroled from the institution, had been at large in the community for from ten months to five years, and the conclusion of Miss Matthews' pamphlet is that, with few exceptions, they are distinctly making good. She speaks of these boys as being "unselected", but from the point of view of the family caseworker, an institutionally trained group of boys is a very selected group indeed. An agency like the Charity Organization Society has to deal with men and women, working boys and working girls, children in school, and children excluded from school, with all degrees of training, down to none at all.

The committee decided to make an intensive study of one hundred of our cases selected only on the basis that a diagnosis of mental defect had been made at least five years previously. It chose, perforce, five years, because it was in the year 1916-17 that the society began first to employ an improved system of differentiated statistics and therefore it was possible to pick out by diagnosis mental defectives of this period without reading through the whole case load. The statistical department supplied the names of one hundred and fifty-six cases closed in 1916-17. The records of all these cases were read, and about one hundred and thirty-five were picked out at random for visiting. About a score were eliminated, either because the diagnosis was in some way incomplete or because the families had drifted away, leaving few or no clues for following them up.

We have talked with institutional workers, parole and after-care workers, in New York, and on the whole have found them optimistic, much as Miss Matthews is optimistic, as to the social prospects of institutionally trained defectives in the community. We noticed further optimism at the Mental Hygiene Conference of the State Charities Aid last August, when more than one doctor said from the platform that the care of the feeble-minded was relatively—i.e., in comparison with the problem of mental disease—a simple problem. One heard the same cheery note also at the National Conference of Social Work at Providence, last June. The slogan seemed to be: Diagnose them early, give them special training, and

for the most part parole them. On the other hand, we found workers in family case-work and workers with children pessimistic. Their attitude seemed to be that case-work in mental deficiency simply meant effort so far out of proportion to results, supervision so much more intensive than they could hope to give, that they were discouraged at the start. Probably these social workers would readily admit that mental defect is, eugenically and medically, a simple problem and that a constructive social program is not difficult to formulate, but in practice they are apt to group all mental defectives together and regard them as a bad job.

Miss Elizabeth Dutcher, in a paper entitled *Possibilities of Home Supervision of Moron Women*,¹ says: "Many thoughtful case-workers who meet other family problems with elasticity and the originality that is born of wide background and much practical experience seem to stop thinking when they approach this problem, to assume a hopeless attitude, and to take it for granted that good case-work is impossible in this field, that the one thing that can be done is to work for better custodial provision for such abnormal persons."

It was especially with the idea of discovering, so far as possible, the nature of a group of cases typical of our characteristically unselected family fields that a long look was directed at one hundred diagnosed families.

As to the accuracy of the statements that follow, any one who has done this sort of family work knows how difficult it is to get really reliable information. In practically every case, at least one personal visit was made, the few exceptions being in cases where the families were actively under the care of another reliable agency. This personal visit was checked, so far as possible, by reports obtained from schools, agencies, relatives, employers, and institutional records, if any, and, perhaps most important of all, by the drift of the case record itself. One found situations in which the family account of the patient's progress did not agree with other records or with facts already in the possession of the Charity Organization Society. One found situations in which the report of a coöperative agency was inaccurate and was corrected only by the merest chance, as in the following incident:

¹ *Proceedings of the National Conference of Social Work*, 1921, p. 273.

A field worker of another agency reported that we need not visit the family of a certain boy as the boy was getting on well, and had been an entirely reliable member of society for some time. His mother and relatives gave a glowing account of him. It happened that the Social Service Exchange had a note that this boy had been recently in the children's court, and the court records supplied the interesting information that he had been on parole for juvenile delinquency for several months. It was quite natural that the mother should give to all comers the sort of glowing account that her apprehensions prompted. She, of course, did not want the boy to go to a reformatory.

Another instance of the difficulty of procuring reliable statistics appeared in this case. Fortunately it happened early in the field work and was an unusual incentive to careful case reading and to checking up wherever possible. We talked for two hours to an intelligent Polish friend about a defective girl, Lulu, whose prognosis in 1916 in the ungraded classes was clearly unfavorable. The Polish friend, however, gave a realistic account of Lulu's success as a nursemaid, giving her salary and the length of time she had held the position. It was hard to believe that our Lulu had done so well, but the friend was convincingly circumstantial. She maintained stoutly that Lulu was much better in "the head", although slow, and it was only after we got up to go that her casual mention that Lulu's job was hard because of her lame leg arrested our departure. Back in that old Charity Organization Society record was an entry to the effect that Lulu's mother suffered from a slight lameness of the left side and from headaches. Carefully we went over the ground again. Suddenly the friend cried out, "Lulu! You mean the one 'sick in the head', not headaches! She died of water on the brain in Passaic in 1919." And sure enough, our Lulu had died of cerebral hemorrhage. Of course, the friend thought we must, in common sense, be talking of the mother, who was living and whose name, he it said, was quite clearly Margaret. The misunderstanding had been complete after a two-hour interview. Here the case history saved the situation, and indeed, inadequate as the old records often were, over and over again the visitor could gently turn character-

istic family euphemisms into the paths of truth simply because here it had been written that Henry had been two years in prison, that the aunts were insane, or that the illegitimate baby had been boarded on Staten Island. We are far from claiming infallibility, but in presenting these simple findings, we wish to make it clear that we have used every precaution that time permitted to secure accuracy.

We should perhaps note that the diagnoses obtainable from clinics and institutions in 1916 were much more cut and dried than they are to-day. The records rarely showed the degree of defect; the patient was simply described by the examiner as feeble-minded or mentally defective, and there was rarely anything descriptive of his social incompetence. We have taken the diagnoses just as they stood, but in most of the cases investigated, there was a strong social presumption of deficiency to bear out the diagnosis.

We have divided our findings into five groups: (A) dependent and antisocial types in the community; (B) fairly social types in the community; (C) indeterminate types in the community; (D) patients who have been sent to institutions; and (E) patients who have died. The accompanying graph (page 319) shows their distribution.

These families, let us remember, were known in 1916-17, after which time active care by the Charity Organization Society was discontinued. In several cases the families had been known intermittently for over twenty years prior to 1916. It is interesting to read records begun in the '90's and to seek the fortunes of the same people in 1922. About a dozen records have been reopened and closed since 1916 and about a half-dozen were actively reopened in 1922 in the districts, but for the most part the Charity Organization Society had done what it could according to its lights at the time—had arranged for treatment, custodial care, relief, training, and what not, as well as it could—and then had discontinued supervision. In most cases, be it said, the Charity Organization Society had advised or even fought for the commitment of diagnosed defectives, for the Charity Organization Society, like most agencies in 1916, thought that commitment was the best solution. Considering the difficulties of the system and the opposition to it, perhaps a surprising number of com-

STATUS OF 117 MENTAL DEFECTIVES

	NUMBER	PER CENT						
Dead	17	14.5						
Fairly social types still in community	20	17.1						
	<table><tr><td>16</td><td>4</td></tr><tr><td>Fair economic adjustments</td><td>Stable marriages</td></tr></table>	16	4	Fair economic adjustments	Stable marriages			
16	4							
Fair economic adjustments	Stable marriages							
Indeterminate types still in community	23	19.7						
	<table><tr><td>11</td><td>12</td></tr><tr><td>Marginal economic adjustments</td><td>Still in school</td></tr></table>	11	12	Marginal economic adjustments	Still in school			
11	12							
Marginal economic adjustments	Still in school							
Dependent and antisocial types still in community	26	22.2						
	<table><tr><td>7</td><td>14</td><td>5</td></tr><tr><td>Incapable</td><td>Promiscuous</td><td>Vagabond</td></tr></table>	7	14	5	Incapable	Promiscuous	Vagabond	
7	14	5						
Incapable	Promiscuous	Vagabond						
In Institutions	31	26.5						
	<table><tr><td>28</td><td>3</td></tr><tr><td>In custodial institutions</td><td>In prisons</td></tr></table>	28	3	In custodial institutions	In prisons			
28	3							
In custodial institutions	In prisons							

mitments were effected either directly or indirectly at this period. We shall discuss this more fully under another heading.

DEPENDENT AND ANTISOCIAL TYPES IN THE COMMUNITY

Our subject here—i.e., the antisocial types in the community, which constitute over one-fifth of our total number of cases—is especially interesting. These defectives are at large now because commitment was recommended, but not followed up, because commitment was recommended and failed, or because commitment was recommended, succeeded, and later the patient was discharged or escaped into the community. For all this group commitment was recommended with greater or less degrees of emphasis by the Charity Organization Society.

(a) *The Entirely Incapable*

We will speak first of those—numbering seven, their chronological ages running from fourteen to twenty-two—who are incapable and at home. These were all, we think—although the record of the older members is not always entirely clear on this point—"exclusion" cases from school, more or less "non-educable", and for one reason or another being cared for at home. In addition to the diagnoses and the obvious descriptions, we have classified them here by the added criterion that if the relatives who care for them now were to die, they would have to be committed as incapable of self-support, or even, except to a limited degree, of self-help.¹

We have two boys of this type, one blind, and the other with tuberculous glands, in addition to the serious intellectual deficiency. Both come from large families that prefer to bear these burdens rather than commit the children. Arthur might get a little training if the family would send him to such a place as The Brooklyn Home for Blind, Crippled, and Defective Children at Port Jefferson, but they are unwilling to do so. At present he is helpless. John, one of eight fatherless children, is an imbecile. He is nine-

¹ The names used in the following case histories are fictitious.

teen and does no work, but is supported by his mother and his brother.

Of the girls, five in number, we found two physically well cared for at home, two idio-imbeciles fairly well cared for, and an epileptic imbecile who was withdrawn from Randall's Island at working age to help the family in its illegal tenement work of flower-making. She can go through the motions, but accomplishes almost nothing. When we saw her, she was admiring herself in front of the kitchen mirror and could not be induced to turn away and talk to the visitor, but kept on smiling foolishly at her reflection.

In two cases the girls are left alone while the mother works. One of them, having early been assaulted, is since kept rather more closely in the house, and now sits around all day quietly, after she has been dressed in the morning, on a stool or wooden box, watching the outside world dully. She makes no effort to run about and play.

The probabilities are that the five girls are too low-grade for child-bearing and the whole seven too docile to get actively into mischief. One would not positively say now in 1923 that all these individuals should be committed, although the environment in this type of family, living in crowded tenements, is not favorable generally for home care. In four of the seven cases the home conditions are tolerable. Three of the seven children had a short period of institutional training—one at Letchworth Village, one at Randall's Island, and the third in Syracuse State School for Mental Defections and a Catholic home; the other four had no institutional training.

(b) *The Sexually Promiscuous*

A number of our antisocial cases are women who have serious sex difficulties and who may be called more or less sexually promiscuous or with little moral sense, to say the least. We distinctly excluded from this group several mentally defective girls who have offended perhaps once, but who have since adjusted themselves satisfactorily to a better social standing. The 1915-16 diagnoses, filed in the records, from Postgraduate Hospital and elsewhere, do not state the extent

of the defect. We do not know how high the patients tested prior to 1916, but only that they were feeble-minded.

One of these women, the sister of a corporal to whom we shall refer elsewhere, claims to have a husband on a tug-boat, but now goes about the streets, clad wretchedly in night-gown and cloak. Both she and her first baby are supported by her already burdened family. She has little self-respect, and we can hope for nothing for her but further degradation.

Mary, another, deserted by her husband, committed her children and is now living with the father of her illegitimate baby. The outlook here, too, is miserable, although her story might have been different with a better husband and home. The present situation will doubtless not last, as the woman has marked sex instability.

Rosie, a third, is admitted by her family to be a prostitute.

Clarinda had a mental age of nine with emotional instability. In 1916 she was left by the Charity Organization Society to the supervision of her church. In 1917 she had been committed to the House of the Good Shepherd for immorality, and although other agencies have been trying to secure her recommitment, since her release, she has had two known abortions and is still at large.

We tried to persuade Margery's mother to commit her after the birth of her first baby, but the family, backed by the minister, insisted on placing the baby out. The child was born just after Margery had left an ungraded class. A second illegitimate baby was born two years later, but the father refused to marry so obviously defective a girl and the second baby was boarded out. Margery has now succeeded in marrying a weak young man with cardiac trouble, her third affair, but this arrangement seems no more stable than the others. Margery's sister, also defective and emotionally unstable, has a "beau" who is epileptic, and the prognosis is equally unfortunate in her case.

These girls are of the high-grade-defective type, but their parents were loath to admit the seriousness of their sex difficulties. Unquestionably, considering their homes, these women should have been committed, for training at least.

Unfortunately, as we know from experience, both clinic and court, as well as the family, do not see the constructive impli-

cations of committing these moron and border-line types for training. If a girl looks "stupid" enough, they will assent to commitment, but if she is pretty and makes a good impression, no amount of social history will convince them that she is of a type that is a far more serious menace to society than individuals of a lower grade of mental defect, and that training for a few years may help make a useful citizen of her.

Lucy, always promiscuous with boys, after a term in the House of the Good Shepherd and other Catholic shelters, was placed, through the Charity Organization Society, on Randall's Island. She ran away in 1916 and had her first illegitimate baby in 1919. Fortunately, two defective sisters of hers, with the same characteristics, were transferred in time to the Newark State School for Mental Defectives. With this girl, as with so many, treatment was begun too late.

A striking case was that of Julia, who came from a miserable and intemperate family known to the Charity Organization Society since 1908. Julia was taken from her wretched home and given intensive training by the Charity Organization Society at a settlement house, where she improved greatly. At domestic service, however, she went under, having an illegitimate baby, with active venereal infection in its train. Although the girl was in a city hospital and commitment should have been easy, the agency that took the case over failed to act, and the girl was removed from the hospital by a church organization and again placed at service, with disastrous results. Her present whereabouts are unknown.

The Charity Organization Society spent much time and money on this girl, and perhaps, in the light of what we know now, it would have been better to have sent her in the first place to a special institution for training rather than to the settlement house, but it is a sorry comment on the weak links of the system that Julia should now be at large, and especially that her social history should have been completely disregarded when she was casually returned to domestic service.

Another Julia, whom the Charity Organization Society wanted to commit, but did not actually attempt to commit, had last December her first illegitimate baby by a morally low-grade defective who already has one child on Randall's Island. There is no protection in her present environment,

and her tendencies are well established. Her father and one brother have been in prison, and the mother, who is "looking after" Julia, is immoral.

Jessie, whom we did succeed in placing on Randall's Island, was withdrawn by her mother at working age against the advice of the institution, and although over-sexed and quite incapable of managing her own affairs, she married a worthless Italian who has twice deserted her and is now away. She is an unstable imbecile.

The histories of the other four women duplicate these and need not be told in full.

One of the worst, because one of the least necessary, of the cases in this group is that of Jerry, who displayed serious sex difficulties as a child, was placed on Randall's Island by the Charity Organization Society, where he was graded as an imbecile in 1914, was removed by his mother when of working age, and is now the father of his defective sister's child.

It is not easy to see our way to dealing with these emotionally unstable, uncontrolled defective persons except by long commitments for training in first-class institutions. Given the disposition and the environmental conditions in the cases cited above, not the Charity Organization Society nor any private agency can at present give the supervision or make the changes necessary to afford reasonable safeguards. Only trained habits plus a fairly good home can protect such individuals as these, and when, as in the instances cited, they have neither, they must surely be segregated. It is unfortunate that before these defectives were released their parents were not required to furnish more evidences of ability to care for them. Once a child is taught to work at all by the institution, the parents see no reason why he should work for the state, and it requires all the patience and firmness that our institutions and agencies can muster to point out the difficulties and dangers of too early release. Certainly a more serious form of parole is indicated, with a large enough field staff for adequate supervision. The foregoing applies especially to Randall's Island, where the turn-over is a serious matter.

Because of the high grade of intelligence of some of these sexually unstable children, the parents cannot be brought to

recognize their difficulties. Only six girls among the foregoing had any institutional care that we know of and these not in state institutions. Two were in Catholic institutions, one was in a nonsectarian settlement and a Catholic institution, two were on Randall's Island and in a Catholic institution, and one on Randall's Island. We shall discuss elsewhere those who are at present in institutions, which include some of the sexually unstable.

(c) *The Vagabonds*

The vagabond constitutes a fairly distinct type, although at the upper end it is hard to distinguish this type from the marginal worker.

At the bottom of the scale is the vicious type, of which the following case is an example. John's father, an alcoholic, died of tuberculosis, his mother is crippled with "rheumatism", and one sister is in a state hospital for mental disease. Our man spent most of his childhood in a home for crippled children. Unable even to learn cobbling, certified as a defective, he was nevertheless released "to earn a living". He now shares a hovel with his old mother, to whom he is abusive, occasionally drifting away to Blackwell's Island or other refuges. He is alcoholic and an inveterate cigarette smoker. He "sells" pencils or gets a precarious living somehow in the byways of the city. Paralyzed in hip and shoulder, morose, sullen, a beggar, he frightens the neighbors into giving him alms and his mother into doing work beyond her strength.

Like him is Peter, who is unable to do any steady or respectable work. This man's occupation, when he has any, is unprofitable. For the most part he stays about the house, twice a month falling into rages in which he throws the cats, the dishes, or anything handy out of the windows. In between times he is sullen and unresponsive. He is probably psychopathic as well as defective.

Next we have a loafer, a less offensive type, who picks up boxes and sells them for kindling or else simply lies around the house, a distinct burden to the household.

Then we have two typical drifters, one of the better class, whose father is a civil engineer. The son, more constitu-

tionally than intellectually inferior, is unable to hold a job or to stay at home, and is reputed to have an illegitimate baby. He has been in trouble at various times. The other, George, a "laborer", would rather loaf than work, and if he does work, prefers to work for nothing. Both are supported by their families until they wander off nobody knows where, to return no one can predict when.

It is hard to decide whether training would be of help to this group. One, the cobbler, without supervision or a decent environment, made no use of his training. Another was given a so-called high-school education, but could never use it. The others had little or no schooling.

The heredity of three out of the five cases is extremely bad, and the solution of their problems certainly does not lie with private case-working agencies. One of these men has been in prison, although we do not know how many times, and two of them have been intermittently on Blackwell's Island, in the correctional institutions. No other institutional care has been given them, so far as is known.

SOCIAL TYPES IN THE COMMUNITY

When we speak of social types in the community, we do not imply any extraordinary achievements in the line of occupation or domesticity. We must measure these families, not against a college or a business background, but by the general level of the families with whom our society deals. Against such a background, the following cases show up on the whole pretty well and over a length of time that should give some emphasis to the description. Sixteen of our cases were found to have made economic adjustments and four satisfactory marriages, if we disregard the eugenic aspects of such marriages.

(a) *Fair Economic Adjustments*

Of the boys in this group, we found one working in a mattress factory at \$18 a week; one for a butcher, at about \$20; one for a drug store, at \$21; one as a driver, at \$20; and one as a taxi driver. Two are in the regular army, one of them, diagnosed "low grade", being a corporal now.

The family of this last, alluded to before, is below normal,

and it is doubtful whether the corporal would ever have made a satisfactory adjustment in the home. He is said to be married, by the way, although we have no verification of this.

James, diagnosed in 1915 at a city hospital as defective, was also reported by his school as feeble-minded. Looked up after six years, he had been at work the whole of that time. After he left school, where he had been so unsuccessful, he learned plumbing. Last winter, his own trade being slack, when many men sat down until times were better, James worked for a poulterer, giving satisfaction, and has since returned to his own trade with improved conditions. At present he is living at home with his mother in excellent, well-furnished rooms, and the family is devoted to him.

Four of these boys were in ungraded classes in 1916. One got his schooling in a Catholic institution. Only two were in special institutions for defectives.

Harry has progressed nicely since he left the Syracuse School for Mental Defectives in 1913. He has worked seven consecutive years in a laundry, earning \$19.50 a week. He was kept on last year when other less regular men were discharged. He is extremely methodical, going—though without much result, we fear—to night school three times a week, to his married sister's on Thursday nights, to the movies on Friday, to the park or zoo on Saturday afternoons, and to church on Sunday. This program is indeed so settled a habit that when his favorite sister died, he still kept on going to see the husband, whom he specially disliked. No doubt the institutional training is the real factor of adjustment here, but the home conditions are also more favorable than in the average case.

We should not fail to note the history of Mike, who was committed to Randall's Island after a serious sex offense and is now working in New Jersey, the steadiest member of the family. An older sister, committed to Bedford Reformatory, has since married a nice chap. The trend of the family is distinctly upward since 1916; both defectives seem really hopeful cases. The only unfit members of the family are two younger sons who spent four years in a sectarian institution. They are dull and shiftless young men who have not yet come

to harm, but will certainly arrive at no good in their present situation. The stability of the older children, with their special institutional training, is in marked contrast to the instability of the younger, although we cannot, of course, infer that the non-special training made for instability, or even that Randall's Island or Bedford are responsible for the success of the older children. There were other favoring factors.

Of our girls, one, carefully supervised by an intelligent mother, works regularly and faithfully in a paper factory. One is in a Fifth Avenue dressmaking establishment. One is a well-liked domestic servant, working in the same family that for many years employed her mother. One has just got her working papers, but has always been so quiet and steady that she may be included here. One, a very low-grade defective, has for four years been giving entire satisfaction in the refectory of a Catholic home for the aged. This last amounts to institutional supervision. The same girl progressed through three Catholic shelters as a child, but with that exception, none of the girls has had institutional care to help them in their adjustments, and none is very likely to marry, although it is rather too early to tell about that, since, with two exceptions, this adjusted group of sixteen are all in the twenties.

(b) *Stable Marriages*

There is no special reason for discussing under a separate heading the women who have made satisfactory marriages, except that they have never been subjected to the test of economic competition outside the home. We should be rash indeed to call any marriage stable, but the outlook in these four cases need not at present arouse any apprehensions.

Helen, always in an ungraded class in school, likes her home much better than her books, and is making an exceedingly pleasant companion and housekeeper to a decent carpenter, older than herself, who likes her docility and dependence.

The second girl made a self-respecting marriage with an intelligent young fellow in Brooklyn who still seems to like

his choice, and considering that she was diagnosed as a socially incompetent moron, she does very well.

The third, an Italian woman, Vincenza, has a veritable genius for making her husbands comfortable. Twice widowed, she finally and again happily married a widower, and her two children and his are thriving together and doing well in school. In view of her diagnosis in 1916, the Charity Organization Society did not wish to make an allowance case of it, and let the family be broken up and the children committed. Vincenza met her third husband on one of her regular visits to the institution where her children were. He apparently divined her special gifts, and indeed she has proved to be an immaculate housekeeper in an attractive, pleasant home. Perhaps the clinic that diagnosed her was wrong. Certainly our evaluation of her social gifts was wrong.

The fourth marriage, that of Mike's older sister, has already been mentioned in the preceding section.

The institutions in which these individuals of the socially successful type spent short periods of time are as follows:

Syracuse State School for Mental Defectives.....	1
Randall's Island and Rome State School.....	1
Randall's Island and a reformatory.....	1
A Catholic home.....	2
Bedford Reformatory	1
Rome State School.....	1

We shall in another paper consider the question of supervision of social types in the community, discussing it from the point of view of a family agency, but at present we are merely giving a cursory history of 117 cases as we found them, without evaluation of the factors involved.

INDETERMINATE TYPES IN THE COMMUNITY

(a) *Marginal Economic Adjustments*

This is a hard group properly to evaluate, but it is familiar to all family case-workers. Individuals of this type manage well enough when employment is easy to get and hold, but are easily discouraged and often laid off, and are neither regular nor responsible. Their environment is generally an addi-

tional handicap. We note here five defectives of the docile type who do odd jobs and make frequent changes.

One of these, Sam, was in Syracuse State School for two years. A glance at Sam's family is revealing as to why this boy does not adjust well to industry. His father has been at Central Islip for acute psychosis. His mother is very dull. His older brother is an imbecile with tuberculosis, and his older sister spent a short time on Randall's Island before her marriage. The younger brother is tongue-tied, and a younger sister choreic and dull. Two children died of convulsions and the youngest child is choreic. Sam works in a flour company, but is inclined to be belligerent, and the family feels considerable anxiety about his conduct.

Another boy left Letchworth Village against the advice of the institution and is now living quietly at home. The family admits that he earns little, but he is easy to control and turns in what he does earn to his mother. The fact is that he is not paying his way, although the family is poor and in need of his help.

Two others, a boy and a girl, cousins, are working for low wages in unfavorable environments. The family stock is low, with immoral tendencies, and the individual members have been of considerable concern to various agencies since 1908. We have no reason to think that this boy and girl will do much better. George's mother first married a deserter, lived with a second man, unmarried, and during the war married a mulatto; she herself was white. Brother John is lame with muscular paresis and a speech defect and has been a truant and thief; Frank is lazy and a truant; and Katy is in an ungraded class. An aunt has an illegitimate baby, an uncle is feeble-minded, and the whole connection shows dirt, begging, child neglect, and immorality. Not all the "Nam" families live in the country.

Another boy was in the children's court for stealing, but since discharge from probation, has been working fairly steadily.

Three boys have married and are making a poor job of it as husbands. One of them, in 1916 under the care of a settlement house, was waiting for admission to an institution. He never went, but served a short enlistment in the navy. In

1920 he married, bringing a bad work history and a roving disposition as a marriage settlement.

(b) *Still in School*

These children were diagnosed in 1916, when they were little things, and are still "getting an education". Six are in ungraded classes. One is a day scholar in a deaf-and-dumb school, and five are being tried in the grades. It is impossible to forecast their future adjustments, although we can make a shrewd guess in some cases.

Katie, in the second grade, is regarded by her teacher as physically and mentally deficient, making little headway. Her family has been known to us since 1902. They were always in marginal circumstances and in danger of being dispossessed. The mother was alcoholic, the father "shiftless", and the children suffering from cardiac trouble and undeveloped. What headway can Katie be expected to make against these odds? Even the little cardiac sufferers are not attending clinic now, and the mental factors in the situation are not being dealt with by any one.

Another girl, Katharine, was discharged in 1917 from Randall's Island against the advice of that institution. This twelve-year-old child, now in an ungraded class, is described as silly, uncontrolled, and quarrelsome.

The other cases in this group sound much more hopeful.

These cases are known to have had institutional care for short periods in the following institutions:

A reformatory	1
Letchworth Village	1
Syracuse State School and Randall's Island.....	1
Catholic Protectory	1
Randall's Island	1
A Catholic home.....	1

PATIENTS NOW IN INSTITUTIONS

Rather to our astonishment, we found thirty-one individuals at present in institutions. When we made our investigation, three were in prison. Discussing them first, we should say that prison and reformatory sentences are not infrequent among our markedly handicapped patients, the mental defectives. In fact, we found fourteen individuals known to have

served prison sentences in this group of 117, but only three were actually in prison when we went to look the family up.

Over in "Hell's Kitchen" lives a family known to us in its various ramifications since 1894. A block or two in that neighborhood are made miserable by their intermarriages. The whole family is promiscuous; one sister is a prostitute, whose defective baby carries out the line three generations since we have known them. There is another epileptic sister with one illegitimate child and five undiagnosed legitimate children, but the brother, diagnosed in 1916, is our special concern. We found that William, an imbecile who had been in Letchworth, in Manhattan State Hospital, and in the Institution for Defective Delinquents at Napanoch, was rearrested in March of this year and is again at Napanoch. His brother, a promiscuous epileptic and moron, who has served terms in Sing Sing and Elmira, is at present out of prison. He, too, should be in the institution at Napanoch and not fathering children on Tenth Avenue.

"Pug", a defective, who had been in the Catholic Protectory and in 1916 in its farm colony, was sent up to Trenton last Christmas for shooting a policeman. His term will be a long one. We should like to think he might be transferred to Napanoch. His brother Joe, also feeble-minded, happened to be out of prison when we visited the family, although he had been arrested five times in the last three years.

Frank completes our trilogy. He had a reformatory history, and from 1916 on efforts were made to place him in Letchworth, but without success. He simply got back to the reformatory. In 1922 he was again in Elmira, but unless something broke down, was actually going to be transferred to Napanoch at last.

These three cases are interesting from the point of view of comparison as it happens that each of these men has had a different institutional preparation for prison. The first was in Letchworth, Manhattan State Hospital, and in the institution at Napanoch; the second in an institution and a farm colony under religious supervision; the third had a reformatory history from boyhood on.

Fortunately we find twenty-eight of our cases in other institutions. Nine of these are at present on Randall's

Island. We will cite one case which illustrates the difficulties of commitment.

The mother here was suffering from a serious cardiac trouble and was undoubtedly a defective. She lost a number of children in childbirth. One baby was smothered, one burned to death, two died of neglect, yet we could not commit her or her two defective children because the father, who kept the family together, wished no interference. It was not until he himself developed dementia precox and was sent to a hospital for mental disease that the Charity Organization Society succeeded in committing the imbecile daughter—even then not in time to prevent the older daughter from having sex relations with a loafer. The mother died in 1920. The older daughter is beyond our reach, but Maud, the younger, is happily still in the institution on Randall's Island.

Nine other cases were on Randall's Island before transfer or recommitment.

One of the children is now in Craig Colony; one in a state institution in North Dakota; three are in Letchworth; two are in Manhattan State Hospital, having psychosis with defect; and one is on Blackwell's Island.

Two of these were adult sisters living in intolerable home conditions, but the commitment would probably not have been effected by the Charity Organization Society had not a psychosis in addition to their defect brought them under the insanity law.

One boy is in Syracuse State School. His family has been known to the Charity Organization Society for twenty years. Their history shows insanity, alcoholism, tuberculosis, and cardiac condition, with immorality and shiftlessness. One daughter, promiscuous and undoubtedly defective, was living with her psychotic mother in questionable surroundings. But the Society for the Prevention of Cruelty to Children, not finding prostitution "proved", would not act, so out of this family we had two juvenile delinquents, one immoral girl, a girl with promiscuous sex defects, and an imbecile boy. The last was the only one to be salvaged and removed from the community to Randall's Island, whence he was transferred to a farm colony at Syracuse.

At Newark State School for Mental Defectives we found

four of our cases; there should have been five. This fifth, already referred to, eloped from Randall's Island before her transfer to Newark State School. Her illegitimate baby was born in 1919, and when last we heard of her, in January 1922, the family was applying to the Salvation Army for further relief. But at least two of the sisters are safely at Newark.

One case history of this period shows the appalling amount of effort necessary sometimes to get commitment.

This child woman of the mental age of nine started living with a man who beat, abused, and finally deserted her. She then lived with several other men. In 1916 a city hospital advised against acting on the representations of the Charity Organization Society, although the woman was diagnosed a moron and had a plus Wassermann and one illegitimate child. In 1918 the matter was brought to the attention of the board of health, which felt that it had no power to act, although the child was neglected and had developed interstitial keratitis. Under constant pressure by the Charity Organization Society, the woman was finally brought into court, but the judge thought she ought not be separated from her baby, and although she was again pregnant, she was not sent to a city hospital for confinement. At the birth of her third illegitimate child, commitment again fell through, although recommended by a representative mental clinic, as the agency responsible for action did not want to make a court case of it "for fear the child's godfather might make trouble". Two of the babies died in the course of time, but when Willis, the neglected and pitiful survivor, came down with pneumonia and meningitis, a children's agency was aroused to action and both mother and child were committed.

Three of our families are still in the Catholic Protectory.

The mother (mental age 6) of a family of eight died, perhaps fortunately, in 1919, before more children could be born. Not all the children are defective, but six of them are still in the institution.

In another family where the mother was undoubtedly defective and possibly tuberculous, since she herself could not be committed, five children, one defective, were removed and placed in the protectory, but she has since added to her family.

A sorry history is Mary's: her father a deserter and

alcoholic, her mother worn out with childbirth, her oldest brother delinquent and committed for larceny. Mary, a moron, was brought into court on complaint of a man whom she accosted. The children's court could not accede to the Charity Organization Society's request for commitment because "the charges were not proved", and she was paroled to her irresponsible father. When the girl was brought into court two years later, there was no difficulty, alas, in proving the charges. She was committed to the House of the Good Shepherd, where she is still. We cannot blame the children's court for not committing on a legal basis, but the father's reputation was well-known and a little competent investigation would have been a preventive measure. Improper guardianship was socially evident.

Of course, it is obvious that commitments mean very little so long as the patients are under working age, for most of the families, unless they think the child ill-treated, are glad to leave them in care of the state during dependency; so it may be well to state here that twenty-one of this group are over sixteen, and only ten under and some of the ten will undoubtedly be left where they are.

The institutional care in these cases has been as follows:

Randall's Island	9
Craig Colony for Epileptics.....	1
State institution in North Dakota.....	1
Letchworth Village	3
Manhattan State Hospital	2
Blackwell's Island	1
Syracuse State School	1
A Catholic home	6
Newark State School	4

PATIENTS WHO HAVE DIED

We can dismiss quickly those who died from causes more or less irrelevant to their psycho-physical condition.

One died of tuberculosis, three of pneumonia following influenza; one died while with the A. E. F., two of children's diseases. There were other defective infants who died, but they do not properly come in this category of cases that were diagnosed before and died after 1916. Three deaths were

accidental and two may be ascribed at least partially to the mental condition of the patient.

George's father was blind and his mother feeble-minded, one sister was in a state hospital for mental disease and another had an illegitimate baby—a poor stock, one observes. George himself, who had been subject to convulsions from childhood, fell before a street car and was killed. George, by the way, had served a sentence in prison. The Charity Organization Society, realizing that with his neuropathic and defective condition, he was not fit for community life and not responsible for the acts that got him into prison, had tried to have him transferred from prison to an institution for the feeble-minded. The prison authorities had promised to make this transfer, but later simply discharged him.

Charles, a docile type of feeble-minded epileptic, escaped from Randall's Island and was working steadily until he was killed by a fall from a ladder.

The third individual was struck by a stone and killed—a purely accidental death, so far as we know.

The group in which death seemed to come as a progressive result of the general condition numbers seven. One, a Mongolian, wasted away; another, withdrawn from Randall's Island, paralyzed and helpless, his only food milk from a bottle, lingered on for eighteen months and died at the age of nine.

Katherine, born "simple-minded", became violent at middle life with symptoms allied to dementia praecox and died in 1918.

Two others suffered from psychopathic conditions and two were epileptic. Several of these deaths occurred in institutions.

The following institutions had cared for these patients:

Bellevue	2
Randall's Island	2
City Hospital	1
Prison	1
Catholic institution	1
Manhattan State Hospital	1

It would be interesting and encouraging to find in these case histories some consistent factor that would illuminate

the causes of behavior. No special knowledge is needed to convince us that emotional instability plus mental defect is a bad combination, but not necessarily a hopeless one. Julia was not the mother of illegitimate babies because her I. Q. was 69, but because her whole personality was abnormal and her environment unfavorable. Generally speaking, the environment in the cases under consideration was unfavorable. Poverty, domestic infelicity, ignorance, overcrowding, and neglect were the rule rather than the exception. Even if we knew more than we do about character, personality, affective disturbances, and the rest, the personality studies in 1916 were far too meager for us to make any guess as to the most hopeful and the least hopeful combination. Almost no personal or environmental evaluations were made in 1916.

As Dr. Bingham says, in her article in the issue of *MENTAL HYGIENE* for July, 1922¹: "The deleterious influence of family and companions often greatly overbalances the efforts of a worker to inculcate habits of industry and better personal standards in these mentally defective individuals. Their low critical sense and their high suggestibility make them very dependent on their surroundings . . ."

The surroundings then, as now, were seldom inspiring and it was difficult then, as now, to secure custodial care for high-grade defectives, chiefly owing to the shortage of beds in institutions and to lack of family coöperation. Then, as now, "the system" less often broke down through lack of good intent in commitment cases than failed because of the sheer weight of the ever-increasing demands upon it.

While we have not, for lack of space, shown the conditions of all the 117 defectives tracked down in this field study, the short histories given may at least add color to the graph of distribution. Field agents working with the problems of mental defect, who estimate the asocial and antisocial types in their case load as 4 or 5 per cent of the whole, will think our figures excessive. Perhaps these figures are not typical of figures for mental defectives throughout the state, just as children paroled from good special institutions are not typical of mental defectives throughout the state; neither is the

¹ *The Psychiatric Work of the New York Probation and Protective Association. MENTAL HYGIENE*, Vol. 6, p. 550.

metropolitan district characteristic of the state at large. The Charity Organization Society habitually deals with marginal and socially deteriorated families in which mental defect is one of the sorest spots. Moreover, this field study is concerned with the last decade; field studies in 1932 should be much more encouraging. But we have to take facts as we find them, and the facts here lead us to the conclusion that in this study only about a third—taking the fairly social types plus some of the intermediate types for a period of not less than five years and averaging eight years since a diagnosis of mental defect was made—have without supervision succeeded in making social adjustments. In 1916, as now, resources were lacking in New York City and State for the adequate care and supervision of mental defectives. The schools have only about one-fourth of the necessary ungraded and special classes. It is difficult to get manual training and more difficult to get trade training for defectives in this state. Placement in employment to all practical purposes does not exist. The city and the state lack beds for the permanent custodial type and cannot begin to care for the special training of the colony and community type of defective, who is too often not recognized by clinic or judge as needing careful protection. Much effective service is being mobilized for the care of mental defectives in New York State, but much is still to be done or we shall have the sort of results that this field study indicates. The future is indeed hopeful, but just as it takes vision to see possibilities in a bad situation, so it takes courage and imagination to see the difficulties in a hopeful situation and to maintain poise and perspective when we are in the middle of things. To interpret the workings of the human mind challenges the last ounce of man's capability. The intricate mechanism of the human mind, the whole indefinable range of personality, defy exact labeling or rigid and uncompromising treatment. Though there are not many short cuts in social work, thoughtful investigation, unprejudiced discussion, and unflagging patience do bring us all further down the long road of service.

WHAT THE PENNSYLVANIA VILLAGE HAS DEMONSTRATED*

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THE Pennsylvania Village for Feeble-minded Women was established by the legislature of 1913 for the purpose of caring for mentally defective women of child-bearing age. The primary object of the institution is the segregation of these girls and women in order that they may not give birth to children and thus reproduce their mental defects in the coming generations.

At the time when the question of establishing the Pennsylvania Village was before the legislature, two of the main objections urged against creating the institution were that there was no need for such an institution and that a one-sex institution for women was not practicable and had never been successful.

After many vicissitudes and the lapsing of six years, the legislature of 1919 finally appropriated money for furnishing the buildings that had been erected at the Village and for the maintenance of patients. On December 5, 1919, the institution was formally opened. Since that time patients have gradually been received until the population has reached 147. This represents the present available capacity of the institution, plus nine additional beds that have been crowded into the dormitories. Moreover, there is on file a waiting list of 125 applications for admission. Notwithstanding the fact that practically all the social agencies of the state know that there is no hope of more than an occasional vacancy at the Village before the early part of 1924 and that the construction of the buildings in use does not permit the admission of certain types of cases, these agencies continue to file applica-

* Read before the Association of Trustees and Medical Superintendents of State and Incorporated Hospitals for the Insane and Feeble-minded of Pennsylvania, Hollidaysburg, October 6, 1922.

tions, with the faint hope that a chance vacancy may bring about the admission of the particular patient in whom they happen to be interested.

To those who understand the situation with regard to mental defectives in Pennsylvania, these facts are not surprising; but to those who are still skeptical, they should demonstrate beyond question the need of an institution such as the Pennsylvania Village.

With regard to the statement that a one-sex institution for girls and women is not practicable and has never been successful, it is only fair to say that in the past there has been some slight basis for this objection; but the increase in the number of occupations considered fit and proper for women and the changed political conditions that make women's institutions of more interest to the average legislator have rendered these institutions more practicable and increased their chances of being successful. Experience in the management of the Pennsylvania Village has shown that the advantages gained by having a one-sex institution for the types of mental defectives cared for in that institution outweigh the disadvantages that arise through the absence of a male population. It has frequently been stated that where there is a one-sex institution, women are required to learn and practice occupations for which they will have no use in the outside world. In planning the types of work to be done by the individual patients in any institution, the ultimate disposition of these patients must receive consideration. If a patient is to remain as a custodial case for life, no injustice is done her if in arranging her work the interest of and benefit to the institution supporting her take precedence. But if the patient is to be returned to the outside world as a more or less useful unit of society, all instruction given should have as its primary object the training of her limited mental powers in such a way as to increase to the fullest extent her economic value and ability to be self-supporting; whatever advantage accrues to the institution through the work of these patients should be distinctly a by-product.

The Pennsylvania Village, as constituted under the law establishing it, is essentially a custodial institution and, in the main, the girls in residence have been trained with a view

to making the institution as far as possible self-supporting. There is, however, a small group of girls, composed of those who are most likely to be given a trial outside, who are being trained to be as self-supporting as possible. Should the time ever come when through some system of parole or colonization an appreciable number of the girls should enter extramural life, there will always be a sufficiently large number of custodial cases to carry on the occupations at the Village that are conducted primarily for the benefit of the institution. During the past three years several of the girls have been taught to assist in carpentry and painting; a group always helps when concrete paths and roads are being made or other concrete work is being done. This spring groups of girls, together with the teams and the assistant farmer, cleared from four to five acres of brush land and planted an orchard of one hundred apple trees and three hundred peach trees. The girls have also cleared a large field for agricultural purposes and several pastures since the opening of the institution. In addition, they do all except the heaviest parts of the farm work and have the whole care of truck garden, chickens, sheep, and dairy herd under the supervision of the farmer and the women employees who always accompany the groups. Not only are the girls being taught this outside work, but they are being instructed in all forms of housework—cleaning, bed making, waiting and dining-room work, cooking and baking. They are also learning laundering, sewing, and dressmaking. The above facts should demonstrate that, so far as the Pennsylvania Village is concerned, a one-sex institution for women is practicable.

“Self-praise is no recommendation” and modesty forbids the statement that the Pennsylvania Village is a successful institution. It can only be said that all the milk needed, all the summer supply of vegetables and many of those for winter, quite a little of the meat used, all of the ice supply, and some minor items are being produced with the help of the girls in residence at the Village, and that so far in the history of the institution, it has been unnecessary to apply to the legislature for a deficiency appropriation for maintenance.

The psychological work done during the World War has

shown that there is a far larger proportion of mentally defective men in the general population than had been realized. It is only fair to suppose that mentally defective women are equally numerous. On this basis there must be, at a very conservative estimate, at least ten or twelve thousand such women in Pennsylvania. Slight mathematical ability is necessary to figure out that, if in the nine years from 1913 to 1922 Pennsylvania has provided for 147 of this number, it will be some generations before all the mentally defective women in this state are under care. The group tests made during the World War showed a surprisingly large proportion of mentally defective persons, but many of these individuals were self-supporting and were leading useful lives in the outside world. In view of the absolute impossibility of caring for all the mentally defective persons in the state, experience at the Pennsylvania Village has shown that in arranging for the segregation of such persons, some kind of sifting process should be used and a decided preference should be given to the patients who constitute actual problems, who have shown antisocial tendencies or have come into conflict with the courts. Of course, these are not the easiest or pleasantest cases to manage, as they would include the whole group of delinquent defectives, that *bête noir* of all institutions for mentally defective patients; but by giving the preference to those cases that are the greatest menace to society, the best interests of the state would be served.

As the primary reason for establishing the Pennsylvania Village was to prevent the reproduction of mental defects in the coming generations, it might be well to inquire as to how it is fulfilling its mission. Fifty of the girls admitted here had prior to their admission one or more children, a total of 106 children having been born to them. Twenty-one girls had one child each; seventeen, two children; six, three each; one had four children; two, five children each; two, six children each; and one, seven children. When a mentally defective woman has one child before she is segregated, while there is no increase in the number of mentally defective individuals in the next generation, still there is no decrease; and when she has more than one child, the total number of mentally defective persons in the next generation is increased, even

though by her final segregation the full amount of damage of which she is capable is somewhat minimized. It is obvious that if the Pennsylvania Village is to reach its highest efficiency, the girls will have to be admitted earlier and before they have had so many children. When the day comes when all of the children in the public schools are given mental examinations as a routine matter, just as they are given physical examinations to-day—so that the number and identity of our mentally subnormal population may be more accurately known—there will be a far better chance of accomplishing the segregation of mentally defective persons earlier in life and before they have had any children. Such examinations would also give a better basis for sorting out those youthful offenders who need institutional care from those who can with safety lead extramural lives.

One thing more of importance has been brought out in handling the problems arising at the Pennsylvania Village. The movement of population is not what it should be to permit the institution to care for any large number of patients, as "few die and none resign". When a new building is opened, a sufficient number of patients is admitted to fill that building. Then available space for additional patients is virtually exhausted until the legislature again increases the size of the institution. If the Pennsylvania Village is to reach its greatest efficiency, some means of rendering the population less stagnant must be found. Two groups of cases naturally suggest themselves as being best suited for removal to make way for the admission of other girls. The first is that group whose conduct has been exemplary and who have profited by training and discipline; these girls might be worthy of a trial in some colonization scheme that, while keeping them under observation, would permit them to lead extramural lives. The second is the group of women who have passed the child-bearing period. These women are no longer a menace to the general public and many of them would be useful for a number of years, especially as they are trained in certain kinds of work. The proportion of this group will increase constantly as the institution grows older and unless some plan is worked out to prevent it, will thwart to a considerable extent the purpose for which the institution was

established. Lowering the upper age limit at which patients may be admitted to thirty or thirty-five years might help a little temporarily; but some method of caring for this ever-increasing group of women in some place other than the Pennsylvania Village must be worked out or the benefit of this institution to the state will be greatly lessened.

The Pennsylvania Village has demonstrated:

1. That such an institution is needed.
2. That a one-sex institution is practicable and can be run successfully.
3. That inability to segregate all mental defectives would suggest giving the preference in committing cases to those who are the greatest menace to society.
4. That the commitment of these cases earlier in life is necessary.
5. That there is need of increasing the movement of population at the Pennsylvania Village.

THE JEWISH MIND IN THE MAKING

A LAYMAN'S ESSAY IN MENTAL HYGIENE

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IN discussing the question of the psychology of the Jew, one must present the general problem of mental hygiene—namely, the adjustment of the individual to his environment. Although the settlement of Jews in the United States dates back to 1655, large numbers of them have immigrated since the Russian massacres of 1881. The mental-hygiene problem of the American Jew, therefore, is in part related to the larger problem of the immigrant, who must go through the struggle of adjusting himself to an entirely new environment. But the Jewish aspects of the question involve not only the present environment, but also the very trying conditions under which Jews have lived for about twenty centuries, since the dispersion from Palestine. The problem of mental hygiene among the Jews is concerned with the effect of this historic environment upon their character and upon their mental reactions.

THE GENERAL PROBLEM OF MENTAL HYGIENE.

The general question of mental hygiene has only recently been recognized. Medicine has been concerned exclusively with the treatment of physical disorders—that is, physiological maladjustments—and has discussed problems of infection or of organic diseases. Man, however, is not merely a machine for taking food and developing energy, nor does he react merely instinctively, like the animal, seeking pleasure and avoiding pain; he is a psychic organism, which by the use of symbols like language has magnified its powers almost without limit. Man is the capstone of biological evolution; he sums up in himself the history of animal life. He therefore lives on many planes—the mechanic or muscular, the chemical or metabolic, the vegetative, the instinctive, and the rational,

and at each of these levels he must make his adjustments. The task of mental hygiene is to effect a harmony between the individual and his environment and to avoid such maladjustments as will result in the breakdown of the human psyche. Mental hygiene is concerned, therefore, with all the agencies that have to do with the adaptation of the individual to his environment, such as education, legislation, and the various instruments of social control.

What is the nature of mental maladjustment? At bottom all failures of man to adjust himself mentally to his environment arise from conflicts between the demands of the environment and the ability or willingness of the individual to conform thereto. The worries of the Jewish housewife concerning the minutiae of the Mosaic dietary laws and preparations for the Passover, or of the orthodox Jewish business man concerning either the observance of Sabbath and of the holidays or his traveling "on the road", are not exactly conducive to mental serenity. The taboos of tradition run counter to the imperious demands of twentieth-century life and frequently result in abnormal conduct, which is the external evidence of failure of adjustment. In fact, failure of adjustment becomes evident not from what a man thinks, but from what he does; we are made aware of it only through the conduct of the individual. Most persons have more or less difficulty in making this adjustment to the environment. Some minds, however, are supple, and respond easily to new conditions. Others are rigid and unadaptable. Such minds crack rather than yield. The war neuroses, for example, in which the sudden change to a new and harsh environment caused cases of so-called "shell shock", were merely cases of failure of adjustment.

MENTAL HYGIENE AND THE IMMIGRANT

If one accepts this view of the problem of mental hygiene, one will naturally expect to find cases of so-called mental disease among immigrants, who must adjust themselves to a totally new environment. Detailed statistics of the prevalence of mental disorder among immigrants do not bear out the contention that the foreign born are of inferior stock or are more prone to constitutional mental disorder than the

native born. The mental problems of the former arise from the sudden and sharp demands of the new American environment. As a result the immigrant is more subject than the native to psychoneuroses, to disorders of conduct that occur without any manifest physiologic change or lesion. The difference between the mental reactions of the native and of the immigrant is evident not only in the abnormal individuals, but even in the normal. The native makes an easy adjustment to the conditions of American life; he was brought up in them. For example, patriotism with the native born is unconscious. However, the immigrant who is patriotic is so deliberately and consciously, and therefore frequently, as during the war, protests his Americanism, an act as unnatural and incomprehensible as protesting one's love for one's mother.

Again, changes of environment stimulate effort. The immigrant, therefore, is frequently more energetic than the native. He is a material success in a higher percentage of cases than his children or the other native born. But most newly rich immigrants are of the parvenu type and are unable to develop the seasoned and settled attitude of families economically and socially established. Many of them develop psychoneuroses, visit neurologists, and live in the watering places of Europe. The Jewish immigrant is no exception to this tendency.

Perhaps a sadder case is that of the immigrant who, for economic or other reasons, cannot find an outlet for a gifted mind which is the heritage of centuries. There is the tragedy of wasted lives, of keen intellects, trained in the Talmud, pressing pants or pushing carts, as Ephraim Lilien so faithfully shows in his etching *The Net*. Such spirits occasionally break the bonds of deadening reality and attempt to soar in an atmosphere created by their own imagination—an unreal world, but actual to them. Like Schiller's *Pegasus im Joche*, they sometimes collapse in the endeavor. Their environment differs from the world for which the European Yeshivah, or Talmudical School, trained them, and the conflicts engendered by their attempts to adjust themselves afford a fruitful soil for mental disorder.

THE PROBLEM OF JEWISH MENTAL HYGIENE

Statistics of institutions in the cities where Jews concentrate do not substantiate the charge that there is a higher percentage of mental derangement among Jews. As a matter of fact, Jews furnish much fewer than their pro rata number of cases of several of the more serious and prevalent mental disorders, such as alcoholic insanity and general paresis.

On the other hand, they furnish the largest percentage of the psychoneuroses. The reason is not far to seek. Like every group, the Jewish people is the product of its environment. The environment of the Jew may be said to include not only the economic and social pressure of the Gentile world, but the Jewish spiritual and cultural institutions set up to reduce the effects of that pressure on the Jewish people. This environment persists from generation to generation. In a sense, therefore, the social environment operates like heredity. It is transmitted and affects children to the third and fourth generation.

Sixty generations of persecution and of anti-Jewish pressure are the clear cause of the so-called nervousness of the Jews. Jeremiah recognizes this relation of cause and effect when he states,¹ "Moab hath been at ease from his youth and he hath settled on his lees and hath not been emptied from vessel to vessel, neither hath he gone into captivity: therefore his taste remained in him and his scent is not changed."

As a result of persecution, the Jew has found it very difficult to survive and has been under a nervous strain for generations. For centuries he has been overexerting himself. The laggards and the dullards died, for they were the unfit in the fateful struggle for survival. The Jew has been fighting a battle on his second wind and his attitude is that of the fighter who is tense or the runner who is keyed up. He frequently lacks poise and reserve, which go with leisure and a margin of the comforts of life. He is very intense—puts forth too much energy to accomplish his end. He often speaks loudly and seems excited and overstimulated.

Since acquired characteristics are not inherited, according to the Weissmann theory, one may ask, how can the inhuman

¹ *Jeremiah*, 48: 11.

treatment of the Jews of old affect the conduct of their descendants to-day? Indeed, the persistence of the prepuce in the newborn Jewish male, in spite of the practice of circumcision for over one hundred and twenty generations, is offered as evidence by biologists in support of the Weissmann theory. Nevertheless, the newer psychologists have advanced the theory of racial memory, according to which the individual inherits not only the physical traits of his parents, but also the psychological deposits of previous generations. Just as the earth has old strata of rock upon which the geologically newer rocks are deposited, so the mind, underneath its recent acquisitions of education and modern civilization, has archaic strata or racial deposits of memory and modes of reaction.

As to the mechanism of this supposed transmission, little is yet known. According to recent theory, the so-called ductless or endocrine glands may furnish the physical basis for our mental pattern. For instance, a frightened animal increases its secretion of adrenalin, which results in an attitude of offense and defense, such as dilated pupils, rapid breathing, intense effort, increase of sugar in the blood, rapid coagulation of the blood and clotting of open wounds, and in other manifestations of flight, fight, and fear. The adrenal glands are known to be definitely the cause of certain mental conditions. The same is true of the thyroid, pineal, thymus, and other ductless glands. The Jews, who have been on the defensive and in flight for untold years, have the mental reaction of hyperadrenalism. In fact, Dr. W. A. White puts forth the interesting suggestion that perhaps the unusual frequency of diabetes among Jews may not be unconnected with an excessive secretion of adrenalin, resulting in increases in the sugar content of the blood.¹

To return to some of the other characteristics that have resulted from the persecution of the Jew, it is characteristic that in times of trouble members of a family become particularly tender toward and solicitous for one another. Danger strengthens family ties. Perhaps the pure and devoted family life for which the Jews have been noted may be due

¹ See his *Mechanisms of Character Formation*. New York: The Macmillan Company, 1916, p. 257.

to the fact that they have preserved this defensive reaction of a group under attack. Some students say that it is pathological.¹ However, the persistence of the Jews—indeed of all of modern society as we know it—may be due to the integrity of the family unit, as has been pointed out by Foster Kennedy.²

The persecution of the Jew in the past resulted in his flight from land to land like a hunted animal and in the exaggerated development of certain defense reactions. In order to survive, he had to be high-strung, on the *qui vive*, sensitive to stimuli, with a low threshold of consciousness and lacking in poise, and, like the hunted animal, self-deprecating. These mental reactions are frequently found in the modern Jew.

Again, under continuous oppression, the Jew found relief in an unreal world conjured forth by an unbridled imagination. The great wave of mysticism in the thirteenth century known as Kabbalism, and the intensely emotional Hassidic movement of the eighteenth century, are the historic evidences of such a psychologic reaction. They are the spiritual fossils left by the stream of time on the sands of Jewish institutional life.³

The Jew, for centuries shut out from the creative world of western Europe, lived in the world of fantasy that Zangwill so vividly depicts, and although occasional children of the ghetto, from Spinoza to Bergson, have lived out their genius, the impulse to dream frequently outran the capacity to execute and the contrast between aspirations and achievements occasionally led to divisions of personality, while

¹ See *The Adjustment of the Jew to the American Environment*, by A. A. Brill. MENTAL HYGIENE, Vol. 2, April, 1918, p. 223.

² See also "War-time Gains for the American Family", by James H. Tufts. *International Journal of Ethics*, Vol. 30, pp. 83-100, October, 1919.

³ See *Studies in Judaism*, by S. Schechter. New York: The Macmillan Company, 1896. Chapter I. *The Chasidim*. In this study the late Dr. Schechter presents the movement as a reaction from the austere and legalistic aspects of Jewish life. However, in the opinion of the writer another equally plausible interpretation may be the sense of relief afforded to Jews in impoverished ghettos in Poland by an imaginary world in which miracles by the *zadik*, or leader, were daily occurrences. This view is supported by the fact that the Hassidic movement thrived particularly in Poland, the Jews of which were the most poverty-stricken of any in Europe. The prosperous, yet very legalistic, Jews of Holland and Germany were unaffected by the movement.

mental strain frequently produced discontent and cynicism, sadness and madness.

Another result of the centuries of persecution was an attitude of defense which, in the case of the Jew, did not take the form of physical retaliation, but of mental compensation for injuries suffered. Herded in ghettos and hounded, he did not develop a strong physique. He, therefore, did not vent his wrath in physical blows, but found relief in harmless gestures. Some of the familiar instances in orthodox life are the Sabbath Zokor, the Sabbath of Remembrance, on which the memory of the harsh treatment of the ancient Israelites by the Amalekites is recalled, with a petition to the Lord to annihilate a race long since extinct, or the practice of stamping upon the synagogue floor and jeering at the mention of Haman's name during the reading of the Book of Esther on Purim eve, or the recital at the Passover services of the passage in the Psalms, "Pour thy wrath upon the heathen who have destroyed Jacob and wasted his inheritance." In the modern drama perhaps a typical instance of this mental reaction of the Jew is the leading character in *The Auctioneer*, who gnashes his teeth and threatens a blow, but never lets his fist fall. This is the attitude of the introverted type, that reacts not outwardly, but inwardly, that suffers in silence and turns the other cheek to the smiter. Strange irony of history is this: the Jew's ideal is stern justice, but he has always done mercy; his religion is righteousness and retribution, but he has practiced forgiveness of his enemies; his creed was an eye for an eye, but he has always turned the other cheek. The Jew and the Christian have maintained their own professions and preachments, but each has taken the other's as a code of conduct.

Another effect of oppression by the outside world was the development of an inferiority complex on the part of the Jew. In a society that rates manners above character and *savoir faire* above ethical conduct, the uncouth and unkempt Jew of eastern Europe must seem an inferior. Furthermore, before the modern age the Jew wore the yellow badge on his gabardine, but felt an inward superiority, which was expressed in the doctrine of the election of Israel as the "servant of the Lord" and "light to the nations". Since the age of en-

lightenment, when European culture overtook the once superior, but long static culture of the ghetto, the Jew was permitted to discard his physical badge of shame, but he adopted the stigma inwardly. He now feels that since his culture and people are subject to disapproval, he must be sensitive about his religion and about his association with fellow Jews. The so-called flight from Judaism and from Jewish friends is an evidence of the existence of an inferiority complex upon the part of Jews. This inferiority complex may also result in an attitude of overcompensation in which all criticism of Jewish life is resented and in which the Jewish aspect of every subject is emphasized. On the other hand, there is often a deliberate attempt to disguise the inferiority complex by wiping out differences between Jewish and non-Jewish institutions, even among the orthodox—by observing Christmas, calling Passover "Easter", and giving children non-Jewish names.

Persecution has left the mark of fear on the psychology of the Jew. Just as a whipped child runs into hiding, so, as a result of anti-Jewish pressure, the Jew retires unto himself or to the society of his kind. This reaction is interpreted as antisocial, clannish—he is accused of not being a good mixer. But a brand was seared into his soul during many generations of life in exile and the memory of it is not easily forgotten.

Exclusion from guilds of artisans, restrictions on owning land, prevented the Jew from engaging in those occupations that call for the large muscular responses. His sudden and frequent expulsions from one place after another required him to concentrate his wealth in portable form, and his freedom from church regulations as to interest made him the money lender. As Werner Sombart has pointed out,¹ the dispersion of the Jew in many lands made him the international trader and banker. These occupations restricted his muscular expression, stunted his motor mechanism, and afforded none of the relief from mental tension that is obtained through the exercise of the large muscles of the

¹ *The Jews and Modern Capitalism*. London: T. Fisher Unwin, 1913, pp. 13, 28.

trunk and of the limbs.¹ No small part of the high tension of the Jewish mentality is due to this cause, which is being overcome in the modern Jew by the extension of the range of his vocational activities and by hearty indulgence in athletics and outdoor recreation.²

For the Jew of the Middle Ages, the struggle for survival was keen. Life and death frequently depended upon a prompt and adequate response. Just as a step-up transformer raises the voltage of an electric current, so rigid conditions of life raised the mental tension of the Jew. As a result of rapid living, the Jew matured early and aged early, both physically and mentally. Now, G. Stanley Hall, applying the Aristotelian doctrine of catharsis, has pointed out that sound living at any stage of an individual's career requires full development during preceding stages.³ In other words, a "slow hatch" produces a normal maturity. The Jew missed his childhood and therefore lived an abnormal adult life. The modern recognition of the claims of child life may do much to remove this cause of mental disorder among Jews.

The early maturing of the Jew may have been part of the compensation of nature, which is exemplified in other directions. For instance, after great wars in the past that depopulated a country, the birth rate rose, and it is said that males predominated among the new-born, thus making good the ravages of war.⁴ This self-corrective attempt of nature may possibly be in part the cause of the daring modes of dress adopted by women, of the relaxation of standards in the drama and in other social institutions, and of many other post-war social phenomena, whose aim seems to be to restore the decimated populations.

Perhaps the early physiological maturing of Jews, which has been noted as a medical fact, and their fecundity under persecution since the days of the Pharaohs, may likewise be a

¹ See *Youth*, by G. Stanley Hall. New York: D. Appleton and Company, 1907. Chapter II. *The Muscles and Motor Powers in General*.

² See *The "Nervousness" of the Jew*, by Abraham Myerson. *MENTAL HYGIENE*, Vol. 4, pp. 65-72, January, 1920.

³ *Op. cit.*, p. 3.

⁴ See "The Ratio of Male to Female Births as Affected by Wars", by E. R. Shaw. *Journal of the American Statistical Association*, Vol. 18, June, 1922, p. 253.

compensation of nature to maintain the stock under adverse conditions. However, under a more liberal régime the Jewish birth rate declines with that of the general population, and the two-child family is generally prevalent among the middle-class Jews of western Europe and the United States. Many further interesting sidelights might be thrown on the relation of physiological precocity and fecundity to intellectual capacity and mental well-being. However, this would lead us too far afield.

The speeding up of the mental capacity of the Jew explains the peculiar statistical dispersion of ability noted by the late Joseph Jacobs¹: namely, that Jews differ from non-Jews in that they are clustered about the extremes of a statistical grouping—that they have a larger percentage of deaf mutes and of musically gifted, of the color blind and the artistically talented, more paupers and more millionaires, more genuises and more idiots. They seem to be deficient in the average, the middle group of the statistical array. They do not present the typical statistical curve. The explanation may be that only the keen-witted Jews survived, that the average were lost in the stress of life. Perhaps, by another compensation of nature, she struck her averages by pairing off the extremes. The range of capacity among Jews is wider, but is distributed on opposite sides of the normal line. The milder conditions of existence of the modern Jew will probably result in the subsiding of his mental tension and the restoration of the normal statistical grouping of the psychological traits of individual Jews.

One naturally asks how, in the face of these difficult conditions, it was possible for the Jew to maintain his mental equilibrium during the dreary centuries. The answer is, his sublime faith, for the sake of which and by means of which he suffered in fortitude and died in hope. The loss of faith on the part of the modern Jew is to some extent, no doubt, the cause of his abnormal conduct and his nervousness. His faith-nurtured and now faith-starved soul, therefore, turns to new creeds and fads as a substitute support in his mental difficulties.

¹ See his *Studies in Jewish Statistics*. London: D. Nutt, 1891. Appendix B. *The Comparative Distribution of Jewish Ability*, pp. xli-lxix.

EFFECT OF CHANGES OF ENVIRONMENT ON THE PSYCHOLOGY OF
THE JEW

The modern Jew is in part the product of the civilization of a Europe emerging from barbarism. He is not inherently a peculiar character. Indeed, any people subjected to the same difficult conditions would very likely develop traits similar to those of the Jew. Probably the Christian Armenians under Mohammedan rule are the nearest case in point.

Proof is abundant that the mental characteristics of Jews are largely the results of their environment, past and present. In fact, the differences evident to-day between Jews of the several countries indicate clearly the effect of environment on their traits. The tolerant atmosphere of pre-war Austria and Hungary produced an unusual quota of Jewish professional men, legislators, and scholars, and evolved a genial and gentle type of Jew. On the other hand, the German Jew, restricted in army and university life before the war, but unhampered in business and in scientific research, produced *entrepreneurs* of the type of Ballin and Rathenau and scientists like Ehrlich and Wassermann, who helped to create the great Germany of pre-war days. And so on. The Polish and Russian Jew, energetic, at once spiritual and iconoclastic, was the creature of his unfavorable environment, and the traits of any one generation of eastern European Jews are to be assessed in the light of the conditions that produced them.

Change the environment of the Jew from the Russian ghetto to free America and his character changes. As he assimilates the culture of American life, he becomes reserved. Children of the second generation lose a good many of the traits of the persecuted Jew. They are less high-strung, less devoted to the family, more poised; they are better social mixers; they lose the sense of inferiority. However, social ostracism of and discrimination against the Jew has developed in him a new set of mental traits which characterize the partly assimilated Jew in western Europe and the United States.

Again, the environment of Palestine has a remarkable effect upon the immigrant Jew. Even those who are not in sympathy with the movement for the settlement of Jews in Palestine have reported that the bent-backed Jew of the

Russian ghetto becomes in the second generation a stalwart, clear-eyed marksman and rider, vying in his dare-devil feats with the cowboy of our American West.

IS THERE A SOLUTION?

The recognition of the problem of mental hygiene as a maladjustment of the individual to his environment, and an analysis of the historic effect on the Jew of the rigorous environment in which he has existed, make the solution of the problem of Jewish mental hygiene obvious. The conflict between the Jew and his environment must be eliminated.

By what means, then, may this aim be reached? Either the incongruous elements must be removed or they must be made compatible. First, assimilation of the Jews will eliminate the conflict; physical absorption by intermarriage will do away with the Jew as a separate race and therefore also the problem of his adjustment to the environment. This view is held by some Jews in western Europe and in the United States. Immigration to an environment favorable to Jewish life will also eliminate the conflict. Palestine will, some hope, constitute such an environment. There the Jew will survive and thrive because the environment is not repressive. Finally, the Jew in our own country, for example, may become mentally adjusted to his present environment by working out some rational philosophy and an institutional life in the United States that will harmonize the historic culture of the Jew with the nascent culture of American life and fill in the great hiatuses in the old Jewish life, such as the enforced lack of manual labor, of physical exercise, and of play.

The implications of these three solutions abut on the field of sociology, which is beyond the scope of this paper.

COMMITMENT PROCEDURE AND THE STATE HOSPITAL

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THE matter of commitment procedure is intimately associated with the evolution of the conception of insanity and old and new ideas as to the function of the state hospital. The term "insane" is ambiguously used. In the lay sense, it means strange or unusual behavior, behavior that is regarded as antisocial or dissocial. In the earliest times such behavior was looked upon as the result of a visitation either from heaven or hell. Later, the mystical coloring was discarded and insanity was considered a moral or mental perversion. When the unusual behavior was antisocial, the deviation was viewed as a manifestation of a ruptured personality in which the brutal or animal attributes had been criminally allowed to overcome the higher or social elements. However, if the behavior was not distasteful, socially speaking, it was frequently regarded as merely amusing or clownish, or if it had a religious or political bearing, was sometimes heralded as allied to genius or the supernatural. Many leaders of crowds, uprisings, cults, and so on, have been psychopathic individuals.

The antisocial insane were at first treated as criminals or as demoniacally possessed, and were imprisoned, executed, or punished in other ways that were considered fitting at the time, shocking as they seem now in the light of our present-day standards.

The next stage in the evolution of the attitude of society toward the insane was represented by a wave of humanitarian enthusiasm associated with the doctrine of the moral or religious causation of insanity. This led to the establishment of asylums or hospitals in which the patients were treated by "moral means" so-called—that is by persuasion,

by being placed in beautiful surroundings, and by isolation, which was considered conducive to meditation.

With the rise of materialism in science in general and the development of the concept of cellular pathology in medicine in particular, the formulation that disordered function was due to organic defect began to be applied to the insane also. The realization grew that insanity was a medical problem, and the hospitals in which the insane were segregated were placed under medical management.

During both of these periods, admission to such hospitals was easy, by voluntary application or by the application of relatives or friends. It was in dealings with the antisocial insane that the legal concept of insanity crystallized, finally becoming the only precise definition of the word. Insanity came to mean nothing more or less than a mental condition that called for segregation and subsequent detention, and legal declaration of insanity was resorted to only when a patient's antisocial behavior became grave enough to warrant this definition. Otherwise, the solution of the problem was left to the patient or to those interested in him.

Superintendants of hospitals in those days were autocratic. They wielded absolute power in the matter of the detention or discharge of patients and exerted a wide authority in shaping and influencing opinion in all matters of abnormal behavior. Undue optimism characterized the general attitude toward the curability of insanity in those early days of hospital care. Superintendents published glowing statistics in which the percentage of cures mounted to 90 and 95 per cent. It is interesting to note that these statistics were obtained by compilation from discharges rather than from admissions. Some patients were discharged as cured several times in a year.

From an attitude of optimism and confidence in the hospitals, public opinion—in the face of many disappointments, after high hopes had been raised by unguarded promises and erroneous statistics—changed to one first of skepticism and then of suspicion. The idea that patients were unjustly detained, that corruption existed in the hospitals, that incarceration could be brought about by bribery, and the like,

gradually spread and resulted in legislation that aimed to safeguard the persons of those who were accused of insanity.

Thus began a movement that not only made it more difficult to become a patient in a hospital, but at the same time made commitment more of a legal and less of a medical matter. People were "charged" with insanity and were dealt with in the same manner as those who had committed crimes. Complaint, arrest, detention in jail, trial, a guard of police officers or deputy sheriffs, the exhibition of handcuffs, all the sordid accompaniments of conflict with the law, became the recognized and eventually the only means of dealing with the insane. Court procedure in cases of insanity came to parallel that in criminal cases, in order to insure two things: first, that society should be protected from an individual supposedly dangerous to life and property; second, that the accused individual should not be deprived of his liberty without due process of law.

The pendulum swung from unwarranted optimism to hopeless pessimism in regard to the outlook for recovery from mental disorder. The care of the insane became simply segregation from society when public safety was deemed in danger, followed by a purely custodial régime in an asylum, which too often was politically dominated. The lay attitude toward insanity and hospitals for the insane became eventually a mixture of fear, hopelessness, suspicion, and hatred, capped by a sense of finality, shame, and secrecy, once commitment was executed.

Fortunately, the idea that insanity was ultimately a medical problem persisted and grew. A few revered medical pioneers, studying the segregated cases from a scientific standpoint, developed the theory of mental disorder as a biological reaction. Insane behavior was to them not so much a disease in the ordinary sense of the word, though disease might enter in as a factor; it was the result of the reaction of an individual—perhaps handicapped by heredity, environment, and physical disease—to the situations that he was forced to meet in life. In other words, insane behavior is behavior of the individual as a whole, although in many cases this is conditioned by bodily disease.

Once this notion became recognized, it was soon seen that

actually insane behavior was merely an extreme type or end product, separated from normal or average behavior not by an impassable gulf, but by various gradations of abnormal behavior. Ordinary nervousness, exaggerated moods, tantrums, the use of alcohol and drugs, religious fanaticism, various forms of delinquency, and the like, were recognized as primitive, unhealthy, or inferior modes of reaction of handicapped personalities, different, not in kind, but in degree, from insanity.

Thus we see that the word insanity may be said to have three meanings—the lay meaning, the legal meaning, and the medical meaning. To the layman, the word implies unusual, unconventional, and often antisocial behavior. In the legal sense, it means behavior of such a character as to warrant the segregation from society of the individual manifesting it, and court procedure—often the appearance of the individual in court, in a setting that only too frequently savors of criminality—has been deemed necessary in order to safeguard the liberty of the person charged with such behavior. Finally, we have the medical or psycho-biological meaning of insanity, based on the study of frank cases, usually the end stages of a process that has been advancing for a long time from a recognizable, but usually unheeded, incipency. The medical concept has come to mean abnormal behavior—abnormal in that it is out of accord with and not adapted to reality. The possibility of a wide discrepancy between medical and legal concepts of insanity is thus obvious.

Until comparatively recent times the state hospital for the insane has been closed to all but the legally insane. Those pioneers of psychiatry who were responsible for the biological concept of mental disorder soon saw the broad significance of that concept and recognized two outstanding facts. They saw, first, that the roots of the disorders that eventuate in commitment extend months or years back into the past and involve a wide variety of factors, chief among which are heredity—with its effect upon constitution, both mental and physical—individual personality make-up, and environment, including disease and social factors. Secondly, they saw that many cases that came under the medical notion of insanity and abnormal behavior were denied the service and attention

that their condition warranted because they did not fall within the legal category of insanity. They realized that the psychiatric viewpoint and method of approach, developed behind the walls of the insane hospitals in their isolation from the world, could be very profitably applied to this class of cases and to many other problems of social inadequacy—delinquency, prostitution, mental deficiency, constitutional personality peculiarities, problems of industrial unrest, and so forth. Thus began the extramural ramifications of psychiatry and the modern mental-hygiene movement.

It was one of the first principles of this new movement that admission to the state hospitals should be made easier and that the commitment procedure should be, as far as practicable, shorn of its legal features, to do away absolutely with the idea that it was a crime to be insane, a conviction that many of the committed patients had had firmly fixed in their minds by the time they reached the hospital. It was realized that many cases of mental disorder, though not legally insane, would derive great benefit from treatment in a state hospital, especially when such hospitals should have adjusted their policies to the new conception of insanity. From a passive rôle, exercising the function of custody and seclusion of those who had been adjudged insane and therefore dangerous, the hospital was to become active in a reconstructive, reëducative sense. The first step in this new program was the enactment of the voluntary-commitment law, which permitted suitable cases to enter the hospital without court procedure and without the sacrifice of civil status. In many states this is the only step that has been taken in harmony with the modern trend of psychiatric opinion.

Except through use of the privilege of voluntary commitment, the only way into many of our state hospitals is by way of the sheriff's office, the jail, and the court room. There is nothing that the average citizen more cherishes than the sense of being a member of society, one of the herd. To be arrested or accused or in any way touched by the hand of the law is symbolic of being outside the herd—an outcast from society. Nothing is more conducive to feelings of self-abasement, humility, and inferiority than the accusation of antisocial behavior. Many psychiatric conditions depend for their

abnormality upon exaggerated emotional states of depression, feelings of inadequacy and self-condemnation, suspicion, and the sense of being persecuted, with the attendant emotions of fear and hatred. The psychological effect of the routine commitment procedure can readily be imagined; nothing could be better calculated to produce or exaggerate a conviction of disharmony with society. With this conviction will necessarily go an undesirable, unhealthy emotion—depression, rage, hatred, suspicion, or what not. Frequently handled by persons utterly unfamiliar with the care of insane patients—persons accustomed to the custody of hardened criminals—perhaps kept for days in jails, too often vermin infested, is it strange that our patients build around them a wall of hatred and suspicion, or develop a conviction of sin and unworthiness that it may take months to overcome?

In view, then, of the best modern psychiatric thought, it would seem that the present methods of dealing with the insane in many communities are fundamentally inadequate, both psychologically and from the utilitarian standpoint. If abnormal behavior is a medical problem, then it should be, in so far as practicable, dissociated from its present legal management, and admission to the state hospitals, the centers of psychiatric medical activity, should be made easy rather than difficult and humiliating.

The disorders of the mind that ultimately culminate in what may be called legal insanity—a condition in which the patient is dangerous to life and property—are frequently of slow and insidious growth, so that often it is impossible to determine at just what point a peculiar personality ends and disease begins. In this long process, proper guidance, applied early, could without doubt often alter the course at various points for the better. It seems highly probable that we could help such early cases if we could bring our assistance to bear when their difficulties first arise.

There are many cases of mental abnormality, often not legally insane, whose problems could more easily be solved were they removed from their habitual environment. Many such mental states manifest themselves suddenly, and patients suffering from them can often be partially or wholly restored in a comparatively short time. There are many

toxic and delirious states associated with various infectious diseases, with the abuse of alcohol and drugs, with child birth, as well as confused conditions found in senile and arteriosclerotic individuals, which require a combination of physical nursing and psychiatric management available only in an organization trained to deal with mental disorder. In the functional states, so closely akin to a twist or a sidetracking of the personality, many might be saved if we could, at the appearance of the first danger signals—which, perhaps, consist of a vague change of disposition, a loss of interest, worry, hypochondriacal preoccupations, a tantrum, or what not—remove them from their usual surroundings, occupy ourselves with them, enter into their struggles, and not allow them to mull over their troubles alone. If such early cases could be placed in an environment in which stimulation of healthy interests would be the aim, in an atmosphere in which bad mental habits could be disintegrated and habits of satisfaction in some concrete and wholesome activity substituted, in which self-confidence could be gained through the attainment of real efficiency in a vocation possible to the individual in question, a construction rather than a destruction of the personality might very well be the result.

A few communities have altered their statutes so as to make possible the initiation into practice of this new concept. A far larger number, unfortunately, have not. In making the state hospitals centers of mental hygiene, an amendment of the present commitment laws that will minimize the legal aspect of the regular commitment procedure and make admission to the hospitals easier must be the first step.

Instead of continuing to deal only with behavior problems delivered to them by court procedure, the state hospitals can take a second step toward their maximum utility for society by assuming an active and aggressive rôle and reaching out into the community to meet those problems in the pre-commitment stages, as well as other conduct disorders which by their nature are never dealt with inside institutions, but to which the psychiatric method is admirably adapted. The fact that the development of psychiatry has centered around the state hospitals makes it practical and proper to rely largely on them as centers for the extension of psychiatric activities.

The first essential in such a program should be the close affiliation of the state hospitals with the universities and medical colleges. Students should be as familiar a sight on the wards of the state hospitals as on those of the general hospitals. A wealth of material presenting a unique blend of the effects of physical disease and psychological factors on the integrated individual as a whole is to be found on the wards of our great hospitals for the insane. Little use has yet been made of this material for observational purposes. The medical student must be taught to regard a person not merely as a group of separate organs to be studied individually when one or the other may be functioning badly; he must be made to realize that there is an integration of all these units into the personality of the human being that we know, and that the latter and the individual units mutually influence each other. He should be taught so to shape his examination that neither factor is studied to the exclusion of the other, but that each is given equal consideration.

Other means through which the community can be reached are out-patient clinics, traveling clinics, lectures, educational visits to hospitals, and the like. Contacts could be made with all organizations and agencies in the community that may deal with or in any way come into contact with abnormal behavior, such as the schools, the charitable agencies, the courts, employment agencies, industrial organizations, and so on. The aim should be to make it as easy and practicable to secure psychiatric advice as advice in any other medical specialty.

Thus, from the state hospital as a center, there will flow out into the community a steady stream of instruction that will overcome prejudice, allay fear and suspicion, dispel mystery, and gradually eliminate the distinction between ordinary nervousness at one extreme and insanity at the other, by showing that both are but very human, if primitive and childish, modes of reacting to life. In this way will mental hygiene and psychiatry demonstrate their maximum pragmatic value to society.

THE USE OF A TRAVELING CLINIC IN A SCHEME FOR THE NEUROPSYCHIATRIC EXAMINATION OF SCHOOL CHILDREN

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AT THE suggestion of Dr. C. Lincoln Furbush, Director of the Philadelphia Department of Public Health, a clinic was organized for the examination of school children presenting behavior abnormalities. The Lee Special School, Front and Girard Avenue, was chosen for this work, after consultation with Dr. Cornell, of the Division of School Medical Inspection. As the Lee Special School receives children from all parts of the city, it was thought that a study here would yield fairly uniform data and give a good idea of the general problem involved in the disciplinary classes. This selection for a preliminary study proved to be a fortunate one, owing to the unusual interest and coöperation of Mr. Martin, principal of the school, and his staff.

An attempt was made to direct the study of two groups of children—one selected by the teachers as presenting difficult problems of behavior, and the other composed of pupils in two of the upper grades, who, owing to their age, presented a more extensive delinquent career. As the work advanced, our conclusions did not justify this separation of the two groups; they are, therefore, discussed together in our report. In all sixty-two boys were examined.

The examinations of these children were divided into physical, psychiatric, and psychometric. It was hoped that the information collected under these heads would give us many facts with regard to preventive measures and later treatment.

The work of the clinic was carried on by a limited personnel, consisting of a psychiatrist, a social worker, a psychologist, and an internist who had had previous experience in group physical examinations. Miss Ruth Lloyd,

social worker, and Mrs. Dorothy Kern Hallowell, psychologist, rendered invaluable assistance in this study. The histories were obtained by the psychiatric social worker as outlined by the psychiatrist, special emphasis being laid on personality traits and reaction tendencies and the rôle played by situation in the problem. One morning of three hours' duration, each week, was given for this work. The assembly room of the school was quickly prepared by clearing spaces for the examination and by the placement of several screens. Relatives were interviewed and histories obtained for subsequent examinations simultaneously with the physical and psychiatric examinations. The psychological testing was performed in a separate room where quiet conditions could be obtained.

Before we begin to discuss the results of our examinations, it may be well to give a brief outline of the special-school system in Philadelphia. There are eight types of special classes in the Philadelphia schools: orthopedic, nutrition-open-air, nutrition-open-window, English, deaf, sight-saving, orthogenic-disciplinary, and orthogenic-backward.

We were concerned with the orthogenic-disciplinary group. The purpose of our study was simply to gain an impression of the psychiatric material that presented itself in this special school, and to see if a psychiatrist could be of service in handling the school problems of the special classes. It was expected that later we could present a scheme for the organization of a neuropsychiatric examination of school children to be used throughout the city. Our work, therefore, was limited briefly to an investigation of the causal factors involved and to suggestions regarding standardized methods of treatment and prevention.

We did not have the personnel for essential psychiatric social work or the facilities for after-care. It is hoped, however, that these phases of the work can be arranged for later, and the results tabulated after an appropriate period of time has elapsed. As a matter of fact, many of the boys examined were treated later in the city neuropsychiatric clinic. One boy returned to the clinic of his own volition. Throughout our brief work, the best possible coöperation was obtained

from the boys' parents, many of whom realized the need and importance of a neuropsychiatric examination.

PSYCHIATRIC EXAMINATIONS

In the mental examination of these sixty-two children, one was especially impressed by the following psychopathological behavior trends: abnormal seclusiveness; shyness; impulsiveness; sensitiveness; laziness; inattention; excitability; lack of interest; poor respect for authority of any kind, whether school or parental; and bad sex habits, including promiscuity at an early age.

A gang spirit seemed to dominate many of these boys, originating in desire and competition for leadership. Some of them associated their initial school difficulties with the influence of companions, especially older boys. Truancy was often found to have its roots in lack of interest in school work. In many cases the boys gave one the impression of just waiting until they could obtain their working papers. Others seemed contented with the progress already attained and had no desire for further school training after leaving the special class. Some were extremely sensitive about attending a special school, frequently refusing to tell their friends about it. Quite a number were frankly attempting to proceed with their education because of the stimulus held out to them that they would soon be allowed to return to regular classes.

A search was made for initial school difficulties and the exact situations in which they arose. Since the home is the laboratory in which personalities are developed, the mental atmosphere of the home frequently may account for behavior abnormalities at school. The attitude of the parents and their behavior reactions, such as moodiness, indifference, resentment, the attitude of an older brother or sister, petty jealousies of all descriptions, may be reflected in the child's reaction to school work. The importance of these facts has long been recognized in the psychiatric examination of children. The rôle played by situation, therefore, was first considered in the examination of these children. The importance of this rôle of situation has been fully emphasized and demon-

strated in the results of Richards¹. We feel that our findings fully substantiate the validity of her conclusions.

Since we feel it advisable to avoid tiresome case-history reports, the situational data in these sixty-two cases may be briefly discussed as follows: General home conditions were found to have had a marked influence upon the development of personality trends and behavior reactions, not only in school, but also in the home. Such conditions as marked friction between parents, nagging by parents, poverty, dislike of a step-parent, and the like, were frequently associated with the beginnings of a delinquent career. On the other hand, many boys with marked ability had been unable to adjust themselves because of the general inadequacy of home conditions and opportunities. Faulty hygienic routine was a factor in many of our cases; poor eating and sleeping arrangements were the rule. Many of the boys showed the effects of the excessive use of stimulants, especially coffee. Since in childhood suggestibility is a very marked characteristic, it is not surprising that approximately 50 per cent of our cases showed in their initial school difficulties the influence of bad companions, usually older boys.

The rôle of faulty habit formation, usually without parental correction, was noted in many of our case records. These include habits of all types, such as may result, if unchecked by parents, in temper tantrums, panicky outbreaks, carelessness of personal appearance, and so forth. The effect of early experiences in the way of lying and stealing associated with conflict was often evident. The lack of accurate sex knowledge was very marked. Faulty habit formation, with resulting mental conflict, determined the personality make-up and behavior characteristics of many of the boys examined.

PSYCHOTIC REACTIONS

As to psychotic reactions, few actual psychoses were encountered. However, many incipient mental conditions were

¹ Dr. Esther Loring Richards. See *Some Adaptive Difficulties Found in School Children*, MENTAL HYGIENE, Vol. 4, pp. 331-63, April, 1920; *The Rôle of Situation in Psychopathological Conditions*, MENTAL HYGIENE, Vol. 5, pp. 449-67, July, 1921; *The Elementary School and the Individual Child*, MENTAL HYGIENE, Vol. 5, pp. 707-23, October, 1921.

considered to be present, some of which might later develop into definite psychotic manifestations. Many boys showed a tendency toward a depressive reaction, characterized by slowness in planning and thinking and an affective disturbance of depression, usually in reaction to the situation. For instance, one boy who had been deserted by his father and who now has a foster parent was very much depressed because he considered himself a burden; he admitted a feeling of inadequacy and showed typical retardation and mood disorder, such as are encountered in later depressive reactions. This mental condition was found to be associated with his poor school progress and delinquent traits. Other types of disorders such as are covered by affective trends of general elation, with periods of overtalkativeness and overactivity, were encountered in this study. These manic trends were not pronounced, but appeared to be definitely related to those of the adult group classified under the heading manic-depressive insanity. Many boys showed paranoid tendencies. One was considered to show definite schizophrenic manifestations. In many there was a psychoneurotic type of reaction, and this was especially marked in a boy whose complaints of weakness, nervousness, pains in legs, and the like, developed after an operation for circumcision, which he blamed his parents for permitting. He was very antagonistic at home, constantly manifesting traits of irritability, stubbornness, resistiveness, and general incorrigibility, which on two occasions resulted in admission to the House of Detention. Another boy showed an interesting reaction similarly conditioned by an experience he had had some years previously when he was shocked by touching an electric wire. He reacted to this fear by stammering, which has persisted for several years. No organic basis was found for this speech defect, about which he was very sensitive, and it appears to have contributed to his poor school progress and delinquency. In short, examination of these boys made it evident that many of them were in need of definite psychiatric treatment, and in our recommendations many were suggested as in need of further study in a neuropsychiatric clinic. A number of the cases could be admitted to a children's psychopathic ward for further study and observation.

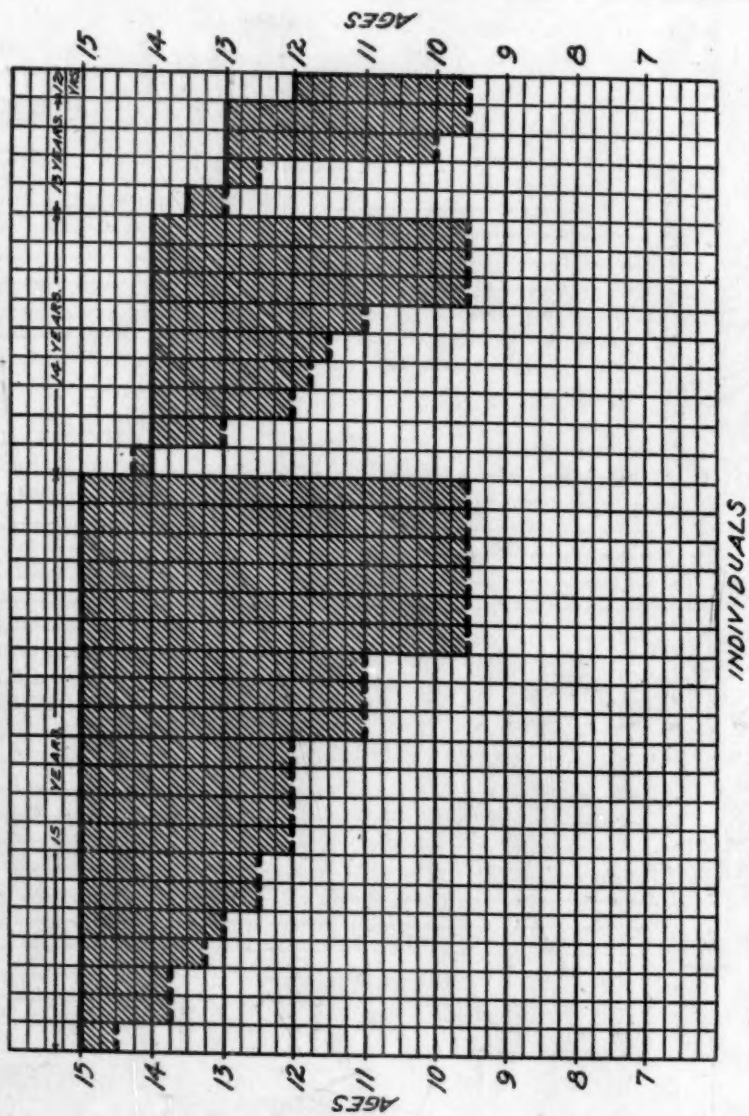
Another striking fact in the histories of these boys was that the majority of them showed neurotic traits during childhood, such as night terrors, bed wetting, thumb sucking, capriciousness regarding food, with the later establishment of definite traits of character associated with initial school difficulties. Considered, therefore, from the viewpoint of personal history, delinquent career, and personality make-up, the majority of the cases were found to be in need of psychiatric study. Furthermore, this psychiatric study would have been more effective if it had been made at the very onset of their difficulties, when their teachers first noticed "marked retardation, truancy, sex misdemeanors, general incorrigibility, larceny, insubordination", and the like. If they had been examined when their school difficulties first appeared, the study of these cases would have proved more satisfactory, better results could have been obtained, and probably many delinquent careers checked. This, however, will be stressed further in our scheme for the neuropsychiatric examination of school children.

PSYCHOMETRIC EXAMINATIONS

The results of our psychometric examinations are very surprising in that they show that a large percentage of these boys were apparently mentally deficient according to the popular Binet tests. This is graphically shown in the accompanying charts (1 and 2). The tests employed consisted of the Short Alpha Group tests, which were given to two of the sixth-grade groups. These tests were on general information such as has been adjusted to routine army examinations. The graphic results showed poor returns; only one boy had a mental age higher than his chronological age. Eleven boys fell below the age level of ten years. Through the use of these group tests, all cases were eliminated in which mental age fairly closely approximated chronological age. The thirty-nine individuals who remained were given the Stanford-Binet tests, Healy A, Healy B, Witmer cylinders, Gwyn triangles, memory span, and Porteus maze. It was possible through these tests to uncover any special abilities or disabilities. For example, the performance tests show ability to handle concrete material, while the Binet tests

CHART 1

DEPARTMENT OF PUBLIC HEALTH
PHILADELPHIA
RESULTS OF 34-68 BOYS WITH ALPHA GROUP TESTS



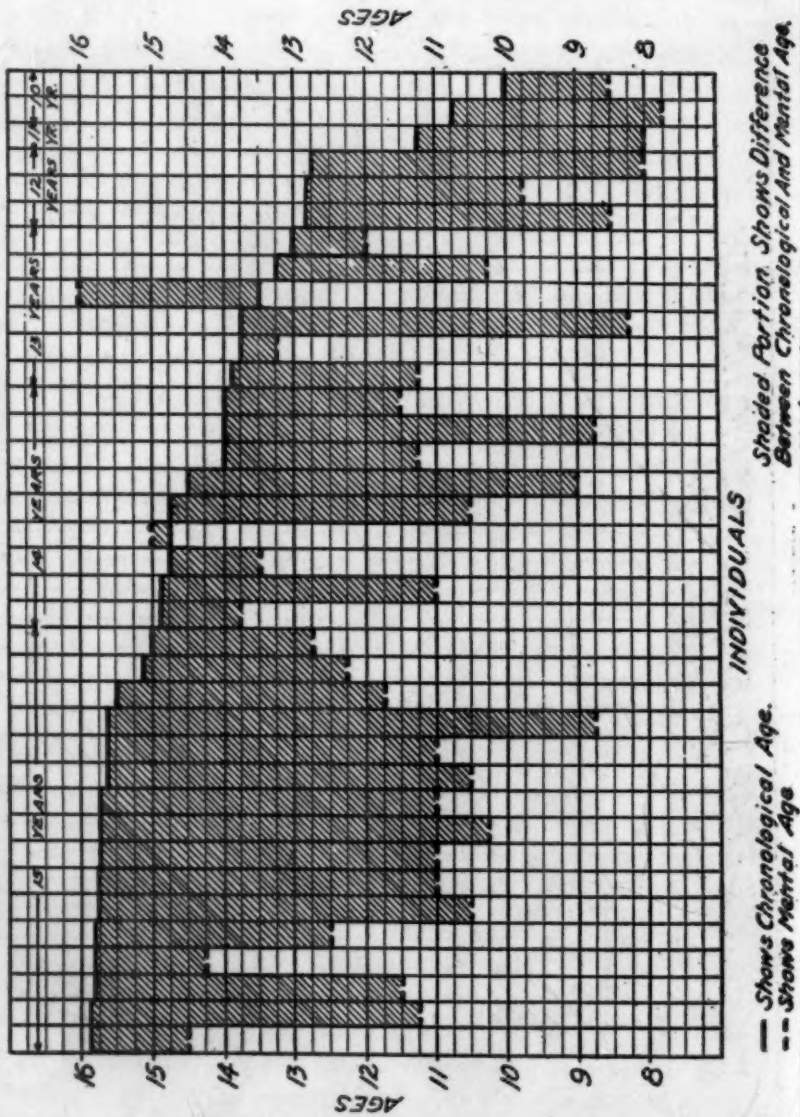
Shaded Portion Shows Difference
Between Chronological And Mental Age.

— Shows Chronological Age.
- - - Shows Mental Age.

CHART 8

DEPARTMENT OF PUBLIC HEALTH
PHILADELPHIA

RESULTS OF 37 BINET TESTS—STANFORD REVISION—



largely depend on language ability and ability to deal with the abstract. One boy refused to take any of the tests. The others were diagnosed as follows:

- 7 as normal
- 2 as slow normal
- 9 as dull normal
- 14 as of border-line mentality
- 6 as moron

Many cases were found in which ability in one direction contrasted with handicaps in others. For example, a Hungarian boy, aged sixteen, in the sixth grade, showed excellent performance ability, but had a marked language handicap and an intelligence quotient of 74, according to Terman, which would place him in the border-line-mentality group. Another boy, an Italian, aged fifteen, showed similar results, the intelligence quotient being 65, which would definitely place him as feeble-minded. Hungarian was spoken in the home of the first lad, Italian principally in the home of the second. The handicap in language ability was in each case found to be due to environment. Another boy had a handicap due to his deafness. The converse of these cases was that of a boy who showed good language ability and poor performance ability.

Since many of these boys have been in special classes for long periods of time, it was not astonishing that they gave very poor intelligence-quotient ratings; for instance, individuals with a long record of truancy, such as a majority of these boys presented, could not be expected to give a normal intelligence rating. We do not, therefore, consider these boys definitely mentally deficient. Their delinquency, lack of uniform teaching, disabilities, personality make-up, reaction tendencies—usually on the basis of some faulty situation—may well explain their poor showing in the tests. Again, we must remember that many of them manifested definite affective disturbances which may have materially influenced the results of the psychological testing¹.

We are beginning to realize the truth recently stated by

¹ See *Influence of Affective Disturbances on Responses to the Stanford-Binet Test*, by Stephen Perham Jewett and Phyllis Blanchard. *MENTAL HYGIENE*, Vol. 6, pp. 39-56, January, 1922.

Scott¹ that as there are degrees of mental defect and mental deficiency, there are also degrees of affective defect and affective deficiency. A faulty emotional reaction, as characterized by periods of depression, anxiety and elation, apathy and indifference, was present in a large percentage of our cases.

PHYSICAL MAKE-UP

Physical examinations were completed on ninety-eight boys. The results of these examinations differ little from other group examinations of this type. I am indebted to Dr. A. B. Nessler, Resident Physician of the Philadelphia General Hospital, for the excellent physical examinations of this group. It was especially significant that one-third of the cases were underdeveloped and undernourished. Regarding physical findings, ten cases were considered to show suspicious signs of tuberculous lesions, eleven had well-compensated heart conditions, and many were suffering from constipation, probably due to a faulty dietetic routine. Six had positive Wassermann reactions. Thirteen were recommended for tonsil and adenoid operations; many others had already had these operations performed. The need of active physical treatment in this group is obvious.

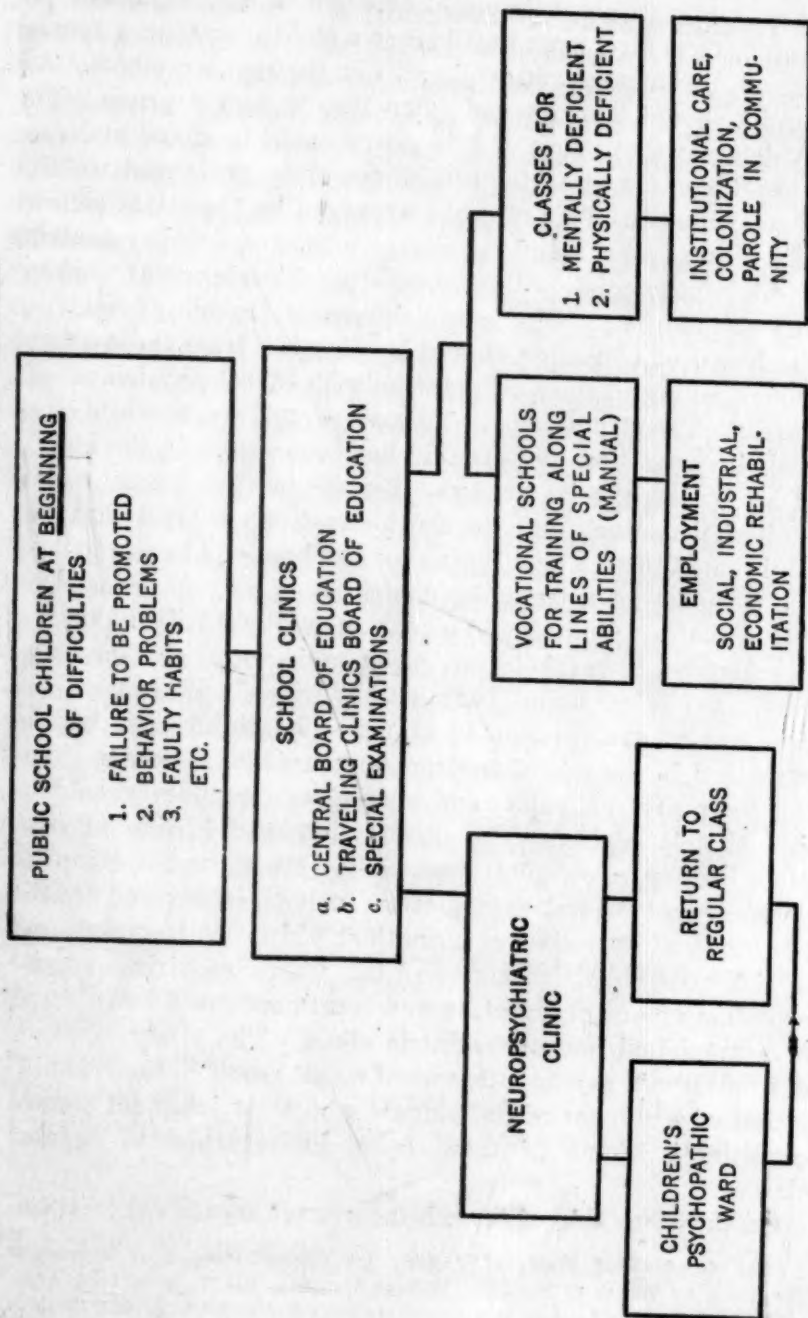
ORGANIZED NEUROPSYCHIATRIC EXAMINATIONS

We feel that the scheme for organized neuropsychiatric examinations of school children is covered in the accompanying chart (Chart 3). It will be necessary especially to emphasize the importance of examining school children at the beginning of their difficulties, and not—as was so frequently the case in our group—from five to ten years later. In fact, the establishment of habit clinics for children of pre-school age is highly advisable. The results of such a clinic have been recently demonstrated by Thom.² Since plasticity of personality, suggestibility, imitativeness, and response to encouragement are greatest during childhood, we can utilize

¹ See *Three Hundred Psychiatric Examinations Made at the Women's Day Court, New York City*, by Augusta Scott. *MENTAL HYGIENE*, Vol. 6, pp. 343-69, April, 1922.

² See *Habit Clinics for Children of the Pre-School Age*, by Douglas A. Thom. *MENTAL HYGIENE*, Vol. 6, pp. 463-70, July, 1922.

CHART 3. NEUROPSYCHIATRIC EXAMINATION OF SCHOOL CHILDREN



these fortunate assets in our efforts to obtain adjustment. We would, therefore, urge that before a child is sent to a special school, he be examined while still in the regular school. All pupils should be examined when they repeat a grade. The evidence is that many of this group could be saved and continue their education instead of spending prolonged time in special classes. This could be arranged by the establishment of a central school clinic in charge of a directing psychiatrist and a psychologist, with adequate psychiatric social workers and clerical help. The establishment of traveling clinics by the board of education should be directed from these school clinics, acting in close coöperation with school physicians and nurses. That traveling clinics have proved worth while since their inauguration by Fernald¹ has been shown in the results of his Massachusetts surveys. Despite brief preparation and limited personnel, and its short duration, we feel that our clinic constituted a real beginning in Philadelphia and proved the efficiency of a traveling clinic.

A traveling clinic should consist, as stated by Fernald, of a psychiatrist, a psychologist, psychiatric social workers, and adequate clerical help. Detailed histories should be obtained previous to examination in clinic. The children should be examined in the school environment in which they are showing their *first* difficulty, and corrective measures should be immediately advised. The examination should include a complete history, a complete personality study, and a complete physical and mental examination such as is covered by the ten heads of Fernald's examination, which has been followed in different form in our records. Cases requiring special examinations or observation and treatment could be referred to a municipal neuropsychiatric clinic. The study of cases in a children's psychopathic ward might result in the rehabilitation of a number of individuals who show incipient mental conditions. Some of these could be returned to regular classes.

On the other side of the scheme are set vocational or train-

¹ See *Standardised Fields of Inquiry for Clinical Studies of Border-line Defectives*, by Walter E. Fernald. *MENTAL HYGIENE*, Vol. 1, pp. 211-34, April, 1917. See, also, *The Inauguration of a State-Wide Public School Mental Clinic in Massachusetts*, by Fernald. *MENTAL HYGIENE*, Vol. 6, pp. 471-86, July, 1922.

ing schools. These would eliminate the stigma attached to special schools, a most important consideration, since many of our boys showed marked sensitiveness regarding their attendance at a special school, and readily admitted, as stated before, that they were just marking time until they could obtain working papers. Under this system of vocational schools, a large number of individuals, usually from the age of ten to fourteen, who apparently are unable to progress beyond the fourth or sixth grade, could receive vocational training that later on would lead to useful employment instead of sentences to the House of Correction, state reform schools, and possibly prison. The recognition of special abilities and disabilities by psychological examinations¹ would help in prescribing this course of study. More attention, interest, and encouragement should be given each pupil.

Other classes for the physically deficient are now provided for. Cases of mental deficiency could be recognized at an early period and assigned to proper schools for their training. At present it is recognized that many individuals whom we consider mentally deficient are able to get along in manual work without institutional care. Furthermore, border-line types of mental deficiency should always have the benefit of the doubt and at least be given every encouragement and opportunity to proceed to the full extent of their abilities. We believe that this scheme is a practical one in that it attempts to meet one of the important mental-hygiene requirements of the community.

¹ See *The Psychology of Special Abilities and Disabilities*, by Augusta F. Bronner. Boston: Little, Brown, and Company, 1917. See, also, *The Individual Delinquent*, by William Healy. Boston: Little, Brown, and Company, 1915.

SPORT OF THE GODS

JESSIE LEMONT

He reached up toward his mother's arms and smiled.
His hands were thin like talons of a bird,
And he could never utter any word
Of pretty prattle like the other child.

And though his body grew, his mind remained
Like a small child's, as though malicious gods
With chuckling laughs, and jeers, and lolling nods
Held in a prison his dark wits enchained.

He was his mother's prayer, she guarded him,
With love enfolded him whom others spurned.
Each draught Life offered him she gently turned
To keep his lips from his cup's bitter brim.

His mother's arms he could no longer find—
Dear God! His soul was like the homeless wind.

—*The Measure.*

ESCAPES

KENNETH SLADE ALLING

The winds and brooks have yielding shapes,
And hence their happy, blithe escapes
From all the forces that would bind them;
And would that God, who has designed them,
Had with more similarity
Made me.

—*The Measure.*

ABSTRACTS

A MENTAL HYGIENE SERVICE FOR PRE-SCHOOL CHILDREN. By Arnold Gesell, Ph.D., M.D. *American Journal of Public Health*, 12:1030-33, December, 1922.

A CLINICAL PRE-SCHOOL PSYCHOLOGY. By Arnold Gesell, Ph.D., M.D. *Mother and Child* 4:64-66, February, 1923.

Dr. Gesell is professor of child hygiene at Yale University and director of the Yale University Psycho-Clinic. In the first of these two articles he points out the importance of mental-hygiene work for children in the pre-school years, and outlines the methods by which such work may be carried on. Psychologically as well as biologically the pre-school period is the most important in the development of the individual, since, mentally as well as physically, it is the period of most rapid and fundamental growth. Most of the physical defects of school children either originated or existed in the pre-school years, and the same thing is true to an astonishing extent of mental defects and abnormalities. From the standpoint of mental hygiene, there are, broadly speaking, three classes of exceptional or problematical children: (1) the mentally deficient; (2) the children with sensory or motor defects that have a tendency to handicap mentally as well as physically—the blind, the deaf, the crippled, and the speech defectives; and (3) the mentally abnormal—the psychopathic, the unstable, the delinquent. In a large majority of cases, the defects from which these children suffer exist and are recognizable in the pre-school years. To put off the special training that such children need until they are old enough for school or for institutional life is to waste precious time. Their training should begin in the nursery. This involves early diagnosis, systematic guidance of home care, and provision for supplementary nursery care and training. A technique must be developed for rendering mental-hygiene service to pre-school children.

A beginning has already been made in this field. The Yale Psycho-Clinic is devoting special attention to children of pre-school age with a view to determining the forms of mental or behavior development in this period and to defining methods of clinical and social procedure in work with such children. The investigation is directed toward personality traits as well as intelligence. The Baby Hygiene Association of Boston is sponsoring a habit clinic in which preventive and corrective psychiatric work is being done with young children, and

educational as well as public-health leaders both here and in England are beginning to stress the social significance of the pre-school years.

Mental-hygiene work for pre-school children can very well be carried on through an extension of the activities of agencies already in existence, as follows: (a) a more systematic supervision of mental development by health and consultation centers; (b) conferences for the guidance of parents; (c) more direct assistance in the home from public-health nurses, psychiatric social workers, and pre-school visiting teachers; (d) adaptations of nursery establishments, kindergartens, and special classes to meet the needs of the more exceptional, handicapped infants; (e) an active alignment of the reconstructed kindergarten with the public-health and child-welfare agencies of the community; (f) pre-parental education dealing with the mental hygiene of child care.

In the second article Dr. Gesell describes briefly the Yale Psycho-Clinic's research work with young children. The purpose of the investigation was "to secure data for defining more correctly and more accurately the behavior traits characteristic of the ascending age levels, in terms of motor development, intelligence, habit achievement, and social reactions". With the aid of graduate students and with the coöperation of the Visiting Nurse Association and the pediatric department of the Yale Medical School, the clinic had, at the time of Dr. Gesell's writing, made individual psychological records of 300 children at the 6, 9, 12, 18, 24, and 36 months levels of development. Fifty children were studied at each level, many of them being retest cases. These children were unselected, "normal" subjects. The two- and three-year-old children were examined in their homes, the others either at the clinic or at consultation centers.

"The method of psychological investigation which we have used with the babies", Dr. Gesell states, "is one of clinical observation rather than laboratory experimentation. The baby is seated in the mother's lap, before a small table. We present him with a series of simple objects and problem situations—an enamel cup, saucer, and spoon to manipulate; a piece of paper to crumple, tear, or fold; a small pellet to pick up; a cube concealed by a cup to uncover; a rod to put into a small hole; a dangling ring to pull down; a third cube to grasp when both hands are full; and so forth.

"Simple as these materials and situations are they have been surprisingly effective in serving their psychological purpose. They have evoked behavior responses almost without fail and have revealed interesting developmental differences between adjacent levels and between individuals in the same age group.

"To delineate these differences is the first task of mental measure-

ment in this field. Although our investigation is preliminary in character, we are confirmed in our belief that the phenomena of behavior occur according to law, that individual differences assert themselves with prognostic import even in babyhood, and that a clinical type of psychology may hope to ascertain some of these differences and offer the findings as an aid in the timely control of human behavior."

THE CONFLICT BETWEEN THE NEW AND THE OLD GENERATIONS. By Abraham Myerson, M.D. *The Family*, 3:163-65, November, 1922.

This is a short discussion of the antagonism that arises between parents and children as the latter leave behind the dependence and physical inferiority of infancy and approach adulthood. With the rapid development that takes place at puberty, the child usually becomes physically the equal of his parents or even their superior. Mentally the parents should still be able to claim superiority, but as a matter of fact, the passing of years, instead of bringing wisdom as it should, often brings prejudices, set habits, preoccupation with narrowly practical affairs, loss of interest in history, literature, and all the larger aspects of life. It is no wonder that children in high school or college often regard their parents as dull and ignorant.

On the parents' side, there is often a certain unwillingness to relinquish authority. "It is not to be forgotten, or covered over by any idealistic delusions", Dr. Myerson states, "that the exercise of power is extraordinarily sweet. To many people the one situation where they exercise power is over their children. It may be good for the child to obey unquestioningly, as is insisted upon by so many parents—I am not so sure that the wisdom of the parents merits this obedience, and further I am sure that many parents are reluctant to give up this tribute to their power and wisdom. But in the history of modern childhood there comes a time when the authority of the parent—that is, his right to power—is first questioned and then silently or openly rebelled against. When the child reaches adult life, an adjustment has usually been made by both parent and child on the basis of the full equality of the latter, but in the interim the struggle between the old and new generations has been acute."

The antagonism between parents and children, which is characteristic to a certain extent of all homes, is intensified in the families of immigrants by the accompanying conflict between the old foreign culture to which the parents cling and the new American culture which the children have adopted. In some cases, such as that of the Russian Jew, religious schism is an added factor in the situation.

Dr. Myerson does not mean to imply that the break between the

educational as well as public-health leaders both here and in England are beginning to stress the social significance of the pre-school years.

Mental-hygiene work for pre-school children can very well be carried on through an extension of the activities of agencies already in existence, as follows: (a) a more systematic supervision of mental development by health and consultation centers; (b) conferences for the guidance of parents; (c) more direct assistance in the home from public-health nurses, psychiatric social workers, and pre-school visiting teachers; (d) adaptations of nursery establishments, kindergartens, and special classes to meet the needs of the more exceptional, handicapped infants; (e) an active alignment of the reconstructed kindergarten with the public-health and child-welfare agencies of the community; (f) pre-parental education dealing with the mental hygiene of child care.

In the second article Dr. Gesell describes briefly the Yale Psycho-Clinic's research work with young children. The purpose of the investigation was "to secure data for defining more correctly and more accurately the behavior traits characteristic of the ascending age levels, in terms of motor development, intelligence, habit achievement, and social reactions". With the aid of graduate students and with the coöperation of the Visiting Nurse Association and the pediatric department of the Yale Medical School, the clinic had, at the time of Dr. Gesell's writing, made individual psychological records of 300 children at the 6, 9, 12, 18, 24, and 36 months levels of development. Fifty children were studied at each level, many of them being retest cases. These children were unselected, "normal" subjects. The two- and three-year-old children were examined in their homes, the others either at the clinic or at consultation centers.

"The method of psychological investigation which we have used with the babies", Dr. Gesell states, "is one of clinical observation rather than laboratory experimentation. The baby is seated in the mother's lap, before a small table. We present him with a series of simple objects and problem situations—an enamel cup, saucer, and spoon to manipulate; a piece of paper to crumple, tear, or fold; a small pellet to pick up; a cube concealed by a cup to uncover; a rod to put into a small hole; a dangling ring to pull down; a third cube to grasp when both hands are full; and so forth.

"Simple as these materials and situations are they have been surprisingly effective in serving their psychological purpose. They have evoked behavior responses almost without fail and have revealed interesting developmental differences between adjacent levels and between individuals in the same age group.

"To delineate these differences is the first task of mental measure-

ment in this field. Although our investigation is preliminary in character, we are confirmed in our belief that the phenomena of behavior occur according to law, that individual differences assert themselves with prognostic import even in babyhood, and that a clinical type of psychology may hope to ascertain some of these differences and offer the findings as an aid in the timely control of human behavior."

THE CONFLICT BETWEEN THE NEW AND THE OLD GENERATIONS. By Abraham Myerson, M.D. *The Family*, 3:163-65, November, 1922.

This is a short discussion of the antagonism that arises between parents and children as the latter leave behind the dependence and physical inferiority of infancy and approach adulthood. With the rapid development that takes place at puberty, the child usually becomes physically the equal of his parents or even their superior. Mentally the parents should still be able to claim superiority, but as a matter of fact, the passing of years, instead of bringing wisdom as it should, often brings prejudices, set habits, preoccupation with narrowly practical affairs, loss of interest in history, literature, and all the larger aspects of life. It is no wonder that children in high school or college often regard their parents as dull and ignorant.

On the parents' side, there is often a certain unwillingness to relinquish authority. "It is not to be forgotten, or covered over by any idealistic delusions", Dr. Myerson states, "that the exercise of power is extraordinarily sweet. To many people the one situation where they exercise power is over their children. It may be good for the child to obey unquestioningly, as is insisted upon by so many parents—I am not so sure that the wisdom of the parents merits this obedience, and further I am sure that many parents are reluctant to give up this tribute to their power and wisdom. But in the history of modern childhood there comes a time when the authority of the parent—that is, his right to power—is first questioned and then silently or openly rebelled against. When the child reaches adult life, an adjustment has usually been made by both parent and child on the basis of the full equality of the latter, but in the interim the struggle between the old and new generations has been acute."

The antagonism between parents and children, which is characteristic to a certain extent of all homes, is intensified in the families of immigrants by the accompanying conflict between the old foreign culture to which the parents cling and the new American culture which the children have adopted. In some cases, such as that of the Russian Jew, religious schism is an added factor in the situation.

Dr. Myerson does not mean to imply that the break between the

two generations becomes serious in every household. "There are", he admits, "parents whose wisdom and love bridge over the challenge of the rising generation, who lift their children into equality gladly, and with a graceful recession of their ego; there are children whose parental love grows into comradeship almost without a hitch or a break." But the fact remains that the need for adjustment always arises. "Within the walls of the home, where rising and receding generations meet, one finds love and sympathy, unselfishness and devotion. Indeed these flourish there as nowhere else. But we who are to face life candidly must not forget that in the same bosoms where these tender and noble feelings grow the opposites, too, are found; that rivalry and competitive feelings range themselves, secretly or openly, against the nearest and dearest. As the young grow, they face their elders critically and with covert or open challenge, and many of those who are so viewed cannot stand the inspection. Out of this situation, and as naturally as the love between parent and child, arises the war of the generations."

WHY MANY NURSES HAVE SHUNNED THE FIELD OF MENTAL HYGIENE.

By Harriet Bailey, R.N. *The Modern Hospital*, 19:358-59, October, 1922.

This paper represents Miss Bailey's reaction to Dr. L. Vernon Briggs' article, *Mental Hygiene in Its Relation to Present-day Nursing*, published in the September number of *The Modern Hospital*.¹ Realizing the justice of much that Dr. Briggs says, Miss Bailey yet feels that the nurses' side of the question should be presented, since the nursing group alone cannot change some of the conditions that are responsible for the reluctance of nurses to take up work with mental patients. This reluctance, Miss Bailey states, is not primarily due to fear or prejudice. It is attributable largely to the fact that until comparatively recently the state hospitals and a limited number of private hospitals offered the only opportunities to secure training and experience in this branch of nursing, and conditions in these hospitals were not such as to attract young women. For one thing, the standards were lower than in the majority of general hospitals. As medical care and treatment of mental patients for so long lagged behind the other branches of medicine, so the standards of mental nursing remained at a lower level than in other fields of nursing. Mental nursing consisted mainly of preventing patients from harming themselves or others, feeding them and keeping them clean, and seeing that they performed as much work for the institution as they were able. In preparation for this work "a few classes were given

¹ Abstracted in MENTAL HYGIENE, Vol. 6, pp. 832-33, October, 1922.

in which the care of the keys, simple precautions against accidents and escapes, and various aspects of hospital housekeeping were emphasized". Moreover, no consideration was given to the comfort of the nurses. They were often required to be on duty for twelve or fourteen hours a day; their rooms were on the wards, often wards in which the patients were noisy or disturbed; they always expected to be called at least once during the night to assist in the management of difficult or excited patients; and no opportunities were provided for their recreation under these trying conditions.

A further point against the mental hospitals has been, and still is, that the nurses are too often looked upon as subordinates, not as co-workers. "They have been made to feel that they must obtain all their initiative from the physicians; that they are principally makers of beds and dispensers of food and drugs. The patient's illness is rarely discussed with them. They never read a history. They know little or nothing of the onset of the illness, the factor or factors which precipitated it, or those which are active in prolonging it. Very little instruction is given to help them to recognize and interpret the mental symptoms, or to apply the most apparent and needful nursing measures.

"What incentive, I ask, can there be for young women to enter upon a work, or keep at it, in which they may be scratched, kicked, spat upon, have their hair pulled and clothing torn, unless they are able to interpret these acts as the expressions of serious mental illness and not of temper or bad disposition?

"How can we expect a nurse to spend long hours with patients who are acutely depressed, or acutely excited, or indifferent or apathetic, and find at every turn that her efforts at amelioration are blocked because she has no understanding of the mechanism of disordered behavior, emotions, or intellect?"

Many nurses who have received valuable training in the care of mental patients are turning to other branches of nursing. Their reason is "that they are discouraged by the outlook, because they have to scramble and grope for knowledge, even to beg for it in order that they may minister at all efficiently to the needs of their patients. They all admit that though the work is hard, it is not too hard, providing they could find satisfaction in it and opportunity for growth and development."

To prove what proper instruction in mental nursing can do in the way of arousing interest in the work, Miss Bailey cites the care of a training school connected with a general hospital that has an active psychiatric department. During the period of training, nurses are assigned to two months' service in this department and are "so

enthusiastic about the work and find the mind is so much more interesting to study and nurse than the body that they invariably ask to have their period of service prolonged, and many elect to give a much longer period to postgraduate study. In this hospital the nurses are given a very carefully prepared course of instruction in mental diseases, the principles and practice of mental nursing, occupational therapy, hydrotherapy, electrotherapy, and mechanotherapy."

The growing need and demand for nurses trained in the care of mental patients can no longer be overlooked. Training schools for nurses are already providing short courses in this subject, which, while they will not prepare a nurse to specialize in psychiatric work, will give her a better understanding of the mental aspect of all her cases. But mental nursing can always best be taught in mental hospitals. Besides offering courses in the various branches of mental nursing, these hospitals should correlate theory with practice by means of adequate supervision on the wards by special instructors or teaching supervisors. "Clinics, too, should be held in which the physicians would demonstrate and explain the symptoms, signs, and treatment of the various forms or types of mental disorder and disease, and outline and discuss the special nursing procedures which are applicable to each."

Physicians who know the need for psychiatric nursing should seek to create the same enthusiasm for this branch of medicine that the internist or the surgeon inspires in his nurses.

EDUCATIONAL CREDO FOR A STATE HOME FOR GIRLS. By Edgar A. Doll, Ph.D. *The Journal of Delinquency*, 7:165-68, July, 1922.

Dr. Doll gives first place in his credo to classification as "the vital element in all corrective treatment of delinquent girls". Based upon a comprehensive study both of the individual girl and her environment, classification should bring to light the probable cause or causes of her delinquency, as well as the contributing factors, and hence should indicate the specific corrective measures to be undertaken to fit the girl for parole.

He believes, further, in a system of time schedules as an administrative device for carrying out the plan of corrective treatment developed for each girl as a result of the classification procedure. The girl's time is the most valuable asset the school has, since it determines the amount that can be accomplished in the way of treatment. It is essential that none of it should be wasted for lack of a systematic administrative procedure. The schedule should show the periods of time allotted for the accomplishment of the desired ends. It should

have a seasonal, a monthly, and a daily aspect to permit of definite daily assignments and yet allow for a certain amount of flexibility.

Thirdly, Dr. Doll believes in a scheme of training with the following aspects:

- a. Social, involving definite instruction in civic organizations and obligations, the relations of the individual to the community, the restrictions of law, and so forth. This phase of the training can be carried on through self-government, coöperative social functions, girls' organizations such as the Camp Fire Girls, and the like, as well as by means of formal instruction.
- b. Religious, including instruction in morals, ethics, and so forth.
- c. Physiological, involving definite instruction in matters of sexual relations, marital and parental relations, personal hygiene, and sanitation.
- d. Physical, including setting-up exercises, gymnastics, competitive sports, and the like.
- e. Recreational, with two purposes—to relieve the routine of institution life and to teach the girls how to use their spare time in wholesome ways after release.
- f. Educational, including both manual and academic training, but giving "relatively greater emphasis to manual-motor or concrete education than to intellectual-scholastic or abstract education".
- g. Industrial, including vocational, trade-industrial, and routine-institutional work. For this branch of the work, Dr. Doll advocates the establishment of a few shop industries in the institution to be operated under the direction of the state and to combine vocational training with commercial production. The training, however, should always be given precedence over the production. He believes that it is possible definitely to train girls in certain occupations which are sufficiently general in all communities to afford a means of livelihood on release, with a good prospect of self-support under favorable conditions.
- h. Domestic, involving the work aspects of home life and emphasizing home-making as well as housekeeping. Many of these girls will marry and this kind of training will greatly increase their domestic stability.
- i. Agricultural, particularly garden work. Besides its specific utilitarian value, Dr. Doll feels that this work has also a general value in inculcating a love of nature and serving as a means of reënforcing the instruction received in other fields of training.

Finally, Dr. Doll believes that, so far as conditions will allow, cottage classification and group instruction should be based upon con-

siderations of color, age, physical condition, mentality, personality, and delinquent tendencies. Realizing the many practical considerations that must be taken into account also, he yet feels that, generally speaking, it is advisable to separate the young from the old, the colored from the white, the normal from the feeble-minded, the diseased from the well, and the stable from the unstable.

BOOK REVIEWS

PSYCHOANALYSIS; ITS THEORIES AND PRACTICAL APPLICATION. By A. A. Brill. Third Edition. Philadelphia: W. B. Saunders Company, 1922. 453 p.

This third edition of Dr. Brill's well-known book has two new chapters, on paraphrenia and masturbation respectively, and some minor additions in the shape of clinical material. The seventeen chapters it now contains present a most varied assortment of topics. Four of them deal with the neuroses, three relate to psychiatry, while others are devoted to such diverse themes as Freud's theory of wit, homosexuality, the only child, analeroticism, the Oedipus complex, the psychopathology of everyday life, and so forth.

The book has a very special claim upon our interest. Its original edition, which appeared in 1912, was the first book on psychoanalysis by an American writer. Together with other manifestations of Dr. Brill's energy and enthusiasm, it has played a definite rôle in creating the widespread interest in psychoanalysis that exists in America to-day. For a long time it was the only American book on psychoanalysis that had the slightest claim to be considered excellent or authoritative; indeed, even to-day it has sadly little serious competition in this respect. Most of the quite voluminous psychoanalytic writing produced in America since Dr. Brill first published this book has been of a very low order and served simply as a background to make his work conspicuous by contrast. The reviewer's task is, then, to examine in the light of present-day knowledge this veteran work, which has not only held a high place in our psychoanalytic literature, but has played a significant part in the history of psychoanalysis in this country. In view of the prominence of the book, this examination should be a rather searching one.

While the different chapters of Dr. Brill's book vary markedly in value when considered from the strictly psychoanalytic standpoint of to-day, all are interesting, some of them extremely so. The chapter that presents the use of the association test—a device, incidentally, that has been generally dropped from clinical use—reads like the best detective story. Meanwhile, it is probably the most successful paper on this test that has ever been written. Likewise, the chapters on Freud's theory of wit and on the psychopathology of everyday life could well be considered classics. They could hardly be surpassed in point of interest, clearness, and accuracy. Even in the chapters

that fall most below the standard thus set, and that show signs, not only of careless writing, but of slovenly and inaccurate thought, Dr. Brill never loses his knack of being interesting. Likewise, despite a tendency to be dogmatic, he is usually convincing, and without ever making concessions from blunt frankness in favor of possible tender-mindedness or sex resistances on the part of his readers. One purpose of the book, as Dr. Brill states in the preface, is to stimulate further interest in Freud's original works. There can be no doubt that it has served this end and will continue to do so.

But when we come to consider the book from the standpoint of present-day theoretical and clinical psychoanalysis, we find that some of the chapters are by no means invulnerable to criticism or deserving of the praise that can be given to those just mentioned. For example, the chapter on the compulsion neurosis—the neurosis, incidentally, that is the most interesting and the hardest to understand and treat of any of the maladies that require analysis—can hardly be considered good, except in a relative sense. That is to say, it is much better than a great deal of the literature on the subject—especially the American literature, which is rather scanty and in general worthless—but we doubt if Dr. Brill's chapter would ever give the reader anything like a clear or correct picture of the psychology of this complex disease. A considerable portion of the theoretical parts of this chapter is made up of two extracts from articles by Freud. The first and longer of the two quotations, occupying something over two pages, comes from a paper that Freud published nearly thirty years ago. Freud has subsequently modified, supplemented, or abandoned most of the views he at that time expressed. Dr. Brill takes a few paragraphs, to form the closing portion of the chapter, from the extremely important, but highly technical paper on the compulsion neurosis that Freud published in 1909. (The quotation marks that might indicate this are absent in several places.) The extracts in question come from the latter portion of Freud's paper and would never be understood or appreciated by anybody who had not read the first part of it. Of the valuable contributions to the psychology of this neurosis made by Freud and others subsequent to 1909, no traces at all appear in Dr. Brill's chapter. This method of expounding theory could hardly be expected to be successful. Those portions of the discussion of theory which are original with Dr. Brill are almost equally unsuited to give a clear picture of this disease.

The clinical material in the chapter is not very well chosen, either. Some of it is totally irrelevant. Extracts from one good illustrative case are given. The rest of the clinical material contributes little to the theme. Some of it is even misleading. Thus, Dr. Brill speaks of the case of a man of fifty-six who, on becoming engaged to a girl

much his junior, began to be obsessed with the idea that he was not fit for the business position he occupied. He felt that he was not sure of his actions, that everything he did was wrong, that he made business mistakes, and so forth. This case, which Dr. Brill tells us was a typical case of doubting mania (it may have been, but the description does not show this), he employs apparently in the attempt to illustrate how the doubt in the compulsion neurosis, which is really a doubt of love conditioned by the activity of repressed sadism, becomes displaced to trifles that have no apparent connection with the love life. But the case, as Dr. Brill explains it, does not illustrate the point at all, but gives what, in our opinion, is probably an incorrect notion as to how the symptoms originated. Thus, he says that the patient "at first worried over the fact that he would not be able to 'make good as a husband' because he believed himself to be sexually impotent. This doubt then became generalized and displaced to all his business transactions. . . . He no longer thought of his impotence, but occupied himself constantly with absurd questions concerning his business affairs."

Thus, according to Dr. Brill, one symptom—impotence—is the cause of another symptom! Surely a novel and astonishing contribution to our knowledge of the etiology of neuroses! We confess our adherence to that group of analysts which, despite this luminous contribution from Dr. Brill, will probably continue in such cases to search the unconscious for the causation of both symptoms. As a matter of fact, the case described by Dr. Brill seems to be a rather clear one. If its resemblance to a familiar type signifies anything, we have a right to suspect that the symptoms originated in a quite different way from the one Dr. Brill indicates. The morbid doubt that spreads through the life of compulsion neurotics is never, so far as we know, a doubt of potency—as Dr. Brill's interpretation would suggest—but a "doubt of love". This term is used in a somewhat technical sense. The doubt of love is not an ordinary uncertainty dependent upon insufficient information, but results from the fact that the repressed sadism in the unconscious of the patient creates a situation in which intense unconscious hatred exists toward all persons whom the patient tries to love. The doubt is an affective, not an intellectual, one. It is not due to an uncertainty of fact, but to two contradicting certainties of feeling. According to ordinary experience with apparently similar cases, we would have to suspect that all the symptoms mentioned in Dr. Brill's case are largely traceable to the two following factors: repressed hostility toward women and the powerful latent sense of guilt which is the usual concomitant of intense repressed hostility. Both of these elements were mobilized by the patient's effort to take a wife. They gave rise, on the one

hand, to his impotence, or fear of impotence, and, on the other, to the feelings of doubt and unworthiness that pervaded his business life. Such, at least, we should be prepared to expect from what an analysis reveals in apparently similar cases. On the other hand, the displaced doubt in the compulsion neurosis never, so far as we know, arises in the way Dr. Brill describes.

Similar shortcomings, both in the presentation of theory and in the choice and interpretation of clinical material, are noticeable in other sections of the book. There is no occasion to try to discuss them all. It may, however, be worth while to take up the chapter entitled *Fairy Tales as a Determinant of Neurotic Symptoms; Their Relation to Active and Passive Allognia*, in which the most numerous and flagrant examples occur.

This chapter is probably the poorest in the book. It is, to be sure, interesting, despite its many faults; it contains instructive clinical material and some rather good dream analyses. But all this material is handled very badly, and the paper is full of irrelevancies, digressions, and hasty conclusions unsupported by the facts.

Dr. Brill's main purpose in this chapter seems to be an attempt to prove, or at least to illustrate, three main propositions. The first is that fairy tales determine dreams; the second, that they determine neurotic symptoms. Having presented material which he apparently considers serves this purpose—though much of it is better suited to illustrate quite different things—he then seems disposed to imitate many of the makers of fairy tales and to close by drawing a moral. His moral, or third proposition, is that the reading of fairy tales is dangerous for children. "Cases such as here described clearly show the harm that such reading may do." He not only believes that fairy tales of the sadistic variety—those that describe killings, beheadings, and the like—causally contribute to the development of neuroses and perversions, but he regards even the milder types as potentially harmful. Persons are caused by them, he thinks, to become "phantastic dreamers". "Having been imbued in childhood with the omnipotence of the fairy-book heroes, they later refuse, or find it hard, to become plain citizens struggling for existence."

These three contentions—or at least the first two of them—are contrary to some of the most fundamental and best established facts of psychoanalytic experience. We are in utter disagreement with all three of Dr. Brill's propositions, and we venture to think that haste and carelessness, of which there is so much evidence in this chapter, rather than Dr. Brill's best judgment, are responsible for them and that he himself, in his more thoughtful moments, would not agree with what he has here expressed. At any rate, an examination of

some of his material will serve to show why, and wherein, we differ with him.

The first of Dr. Brill's three major propositions is that fairy tales determine dreams. In support of this he gives the analysis of two dreams. The first is that of an unmarried woman who dreams that she is chased and caught by a hideous man, who first says he will choke her, but then decides to cut her head off with a big carving knife. She sees the blood flowing and experiences great fright. Dr. Brill relates some of her associations and states that the dream is a coitus phantasy. To this extent we can agree with his interpretation.

But he says further: "The cutting off of her head recalled Bluebeard, who was 'frightful looking on account of his blue beard'. This story was read to her long before she herself could read and made a terrible impression upon her. As she grew older, Bluebeard was the subject of her night terrors, and at puberty she often had dreams similar to the one described."

Such is the evidence Dr. Brill offers us for believing that fairy tales can determine dreams. Apparently he reasons this way: The patient connects the story of Bluebeard with her dream as an association. The story, she says, made a deep impression upon her in childhood, and clearly was connected with earlier dreams. The present dream, then, must have been determined by the story.

We cannot agree with this reasoning at all. We think Dr. Brill interpreted the material incompletely and incorrectly. In the first place, the fact that the patient associated the story with the dream is no proof that the story determined her dream. A patient may give associations to a dream almost indefinitely; yet if, as Dr. Brill would have us in this instance believe, the mere fact that an impression is associated with a dream means that it determined the dream, then we would have to regard each and every one of the ideas a dream calls up as having played the rôle of dream determinants. This is, of course, absurd. The associations that a dream produces are not ordinarily the dream determinants, but merely the material that we study in order to discover how the dream was determined. The fact that the story was associated with the dream is, as Dr. Brill himself should be well aware, no reason at all for thinking that it determined the dream.¹

¹ Dr. Brill apparently uses the verb "determine" as practically synonymous with "giving rise to" or "causing". It is generally used in about this sense by other authors. But it has a little broader meaning than "causing". Thus, the only factor that really causes or gives rise to a dream is a truly unconscious wish. But a dream often represents the fulfillment of more than one wish. We find, for example, dreams formed through the fusion of two phantasies, the one representing the fulfillment of the repressed unconscious wish, the other representing the punishment for it. The wish giving rise to the second phantasy

The only other possible reason for thinking that the story might have determined the dream is found in the history of her earlier dreams. The patient said that in her childhood the story made a deep impression upon her; it was the subject of her childhood nightmares. One might think, therefore, that the story determined these early fear dreams. Granting this, one could then suppose that the dream of adult life was determined in the same way, but that the connection was less obvious—i.e., the story, instead of actually appearing in the dream, was connected with it as an association.

Such reasoning has all the plausibility and all the fallacy typical of conventional thought about such matters before the days of psychoanalysis. We do not agree with any part of it, not even with the apparently easy assumption that the Bluebread story determined the night terrors of childhood. Psychoanalytic experience has taught us the following very important facts, which Dr. Brill leaves entirely out of consideration—namely, that the recollection of various of the fairy tales familiar in childhood and of the emotional reaction to them is carried by the adult in conscious memory *in place of the memories of much more significant emotional conflicts or experiences*. The grown person's recollection of the horror, fright, or other strong emotional reaction to the hearing of this or that fairy tale in his childhood is in most instances really a *cover memory*, in which the persons or events belonging to the fairy tale replace much more significant individuals and happenings. Thus is provided a pitfall for the unwary student of childhood, into which, it appears to us, Dr. Brill has plunged quite as ignominiously as any of his less able predecessors. He took at its face value the patient's estimate of the impression the fairy story made upon her; he overlooked the fact that her recollection of the story was almost certainly a cover memory; he considered it a significant recollection and failed to recognize that it really concealed the significant. In short, it may be seen that Dr. Brill's material was badly interpreted. When we so examine it, we find that it does not support his proposition at all, but can be much better utilized in support of that quite different estimate of the rôle played by fairy tales in the life of the individual which we believe is current among the majority of experienced analysts.

Let us undertake a reinterpretation of Dr. Brill's material in accordance with our knowledge of what analytic experience usually reveals. The meaning of the dream referred to is in our opinion most inadequately stated by saying merely that it is a coitus phantasy.

belongs to the repressing forces and to the foreconscious. Such dreams are said to be "overdetermined". Thus, while only wishes belonging to the deep unconscious can cause dreams, wishes of the foreconscious system also may act as "determinants".

Despite the scantiness of our information concerning it, the dream is so typical a one that we feel justified in venturing to supplement Dr. Brill's interpretation. We feel, in short, that the dream represents a condensation of two phantasies, differing in meaning. The one, to be sure, is a coitus phantasy. But it is a coitus phantasy of a very special sort—one corresponding to the so-called "sadistic conception" of coitus. The other is derived from the "feminine castration complex". We permit ourselves to suspect that Dr. Brill's patient, as a child, went through the two following very typical psychic experiences, and that they, much more than the story of Bluebeard, are important in determining her dream. The first of these hypothetical experiences is that something she saw, heard, or guessed concerning the sex life, presumably of her parents, gave her the characteristic impression that coitus is a painful, bloody, and violent experience which the male (the father) inflicts upon the female. The second is that, upon making the discovery that the male (probably the father) possessed an organ, the penis, which she lacked, she formed the very common theory that originally she too possessed a penis, but that she had been robbed of it, that it had been cut off. Quite typically, the father could be considered the perpetrator of this bloody deed.

In the light of these hypotheses, the material concerning the case immediately becomes transparent. The story of Bluebeard impressed the patient because of the similarity of its content to that of the two themes just described. Bluebeard thus becomes a father surrogate. The impression which this story made upon her—and which it was able to make only by virtue of the elements it had in common with these two other themes—was retained in her consciousness as a cover memory concealing the real incidents that gave rise to her thoughts about castration and coitus. Her childhood nightmares concerning Bluebeard, the dream described by Dr. Brill, and her similar puberty dreams, were all condensations of the two phantasies of castration and coitus. This fusion was readily accomplished by virtue of the similarity between the castration phantasy and the original sadistic notion of coitus. The motive for this fusion is the same as that exemplified by the case of a childless woman who, vaguely perceiving in her sleep the pains that announced the beginning of her menstrual period, dreamed that she was giving birth to a child and that these were labor pains. Thus, the representation of something distasteful (in the case of Dr. Brill's patient, the state of having no penis, of being a woman—castration) is fused with another representation that has similarities of content, but stands for a wish fulfilled. The wished-

for experience of coitus with the male (and of child-bearing) is the natural compensation or indemnification for the missing penis.¹

We can even attempt to explain on the basis of our hypotheses the patient's very singular remark that Bluebeard was "*horrible looking on account of his blue beard*". Ordinarily, were one to pick out as horrible any elements in the story of Bluebeard, his looks and the color of his beard—i.e., visual features—would be among the last things to arrest attention. But if this patient departed from the usual, we must ask ourselves why; and thereupon arises the suspicion that this remark can be related to the penis-castration theme. Is it not possible that the visual image of Bluebeard (who, we think, is a father surrogate) has replaced a visual image of the father, and one in which not the beard, but another appendage not possessed by females occupied the center of attention? And that in this original, but forgotten, scene the notion "horrible" belonged partly to the little girl's shocked, surprised, or envious discovery that her father had this organ which she lacked, and partly to her ideas as to the method by which she had been robbed of hers?

Some of this, in view of the scantiness of the material, may seem rather far-fetched, we readily admit. Indeed, we do not wish to insist that our interpretation of the material from this patient, or our reconstruction of events in her childhood life, is a correct one. For the purposes of our argument, it is not necessary to claim that our deductions are correct for the case of this patient. We *do* claim that what we have hypothesized could be, and very likely is, correct. What we want to emphasize is that, whether correct or not for this particular case, it is a good illustration of what a correct or complete analysis usually reveals in such instances.² The facts so revealed and the conclusions to be based upon them are quite different from those which Dr. Brill invites us to accept.

Space will not permit us to review Dr. Brill's second example of a dream which he considers determined by fairy tales. In our opinion it supports his conclusions even less adequately than his first example. Let us state, then, before proceeding to discuss his second and third propositions, what we consider is a correct estimate of the rôle played by fairy tales in the formation of dreams.

In our opinion the material from fairy tales that often appears in the manifest content of dreams is not to be regarded very differently from any other sort of dream material. The dream material,

¹ A conflict between masculine and feminine traits in the same individual is a frequently observed phenomenon in the neuroses.

² For an example of such an analysis the reader is referred to the interpretation of the dream in Freud's paper *Aus der Geschichte Einer Infantilen Neurose*, in his *Stimmung kleiner Schriften zur Neurosenlehre* (fünfte Folge).

as we know, consists of the various sensory images, mostly visual or auditory, out of which the manifest content of the dream is made. Some of this material always comes from the impressions of the day of the dream; often it includes memories from childhood; but much of it is taken almost at random from any period or experience of life. This material is put together by the dream-forming forces to form a representation, capable of passing the censor, which stands for that phantasy or combination of phantasies, the latent content, which remains unconscious and corresponds to a fulfillment of the wish or wishes that determine the dream. Dream material of whatever sort is thus analogous to cipher, hieroglyphics, printed words, and similar devices used to represent thoughts. Its rôle is merely that of representing. The dream determinants are what motivate this representation. They are not fairy tales, but *wishes*, and especially wishes belonging to the repressed unconscious.

The only way in which the fairy-tale material appearing in dreams is found to differ particularly from other dream material is this: in childhood there are formed in the mind of the individual important connections between his favorite fairy tales and the dominant trends and constellations of his psyche. The fragments from fairy tales that appear in dreams are apt to be especially rich in meaning by virtue of these preformed connections. Fairy-tale material is, from the point of view of dream formation, especially suited to represent infantile thoughts or wishes; from the point of view of dream interpretation, it is apt to form a particularly direct and certain approach to that period in the individual's psychic development which we are most anxious to know about. In all other respects, it is the same as other dream material.

Incidentally, all this has a very practical application. If we share the misconception that fairy tales determine dreams, we will, in analyzing dreams in which they occur as part of the manifest content, commit the error of stopping the dream analysis when the patient has produced mere cover memories, and so fail to carry out that further analysis of the dream which alone could take us into the true unconscious of the patient, as described and defined by Freud. We mistake foreconscious for unconscious material and make one of the commonest and most serious errors in practical psychoanalysis.

Dr. Brill's second proposition—that fairy tales determine neuroses and perversions—we will discuss very briefly. It seems to us absurd on the face of it, and the material he presents makes it no less absurd. The manner of presentation is rambling and disorderly, and much of the material is very badly analyzed. We feel that Dr. Brill must have a psychoanalytic blind spot for the castration com-

plex in view of the frequency with which the clinical material in this chapter shows unmistakably the presence of this complex and the regularity with which Dr. Brill takes no heed of it in his interpretation.¹ Even a lay reader of Dr. Brill's case material would see that it represents not the slightest evidence of what Dr. Brill contends. An experienced analyst would at once recognize that it fits in much better with an almost opposite opinion.

We feel that the main fault of the whole chapter can be summed up by saying that Dr. Brill treats the problem of fairy tales in just the way that patients do. We often hear from a patient that a childhood phobia or series of fear dreams dated from the hearing of this or that fairy story, or we are told that sadistic impulses or phantasies first appeared after reading some tale of whipping or beheading. The experienced analyst distrusts such statements, for he knows that most of these cases are instances of cover-memory formation or some similar affective displacement. In other words, the patients have laid upon the fairy tale the blame for a neurotic or perverse symptom, the real etiological responsibility for which belonged to the persons of the family and the patient's constitutionally predetermined reactions to them. The analysis of cases in which fairy tales might seem to have played a determining rôle shows that, as a matter of fact, the neurosis or perversion was really determined in exactly the same familiar ways as in the cases of those few patients who had never read fairy tales or of that larger number who never claimed to have been affected by them.

Now, as to Dr. Brill's third proposition, that the reading of fairy tales is harmful to children, this assertion, more in harmony with the thought of an elderly spinster than with that of an experienced analyst, is supported neither by the evidence presented nor by the ordinary findings of psychoanalytic experience. It can only maintain itself through the assistance of incomplete analyses, which leave intact the infantile amnesia and fail to reveal the real roots of the patient's character and his disease. The facts are that the reading of fairy tales—even those of the sadistic variety, which Dr. Brill abhors—is in childhood generally not injurious, but on the contrary often serves a definite and useful purpose. We happen to know, incidentally, that such, too, is Freud's opinion. The fact, indeed, that the same fairy tales survive for generation after generation and in so many different nations should, of course, lead one to suspect that they may possess some sort of "fitness". A little study of the types most popular readily reveals how well suited they are to

¹ One of a number of striking examples which should be transparent to any experienced analyst is the patient's distorted narrative of the Bluebeard story on page 369.

coincide with, and apparently to stimulate, those trends and complexes that familiarly rule in childhood. The very characters that might seem to make the fairy tales a source of danger are really the ones through which they do good. Through an imperfect understanding of the situation, tales of blood and horror are frequently withheld from children by parents and educators lest, as seems to be the case, they excite the child and serve as a stimulus to the development of sadistic and masochistic impulses. This is the same type of faulty prophylaxis familiar to us in a closely related sphere. Sex information is withheld from children lest the giving of it awaken sex curiosity. In both cases the educator ignores the fact that the impulse in question—that of sadism, masochism, or sex curiosity, as the case may be—is inborn and normally a constituent of the child's make-up. This ignoring is generally conditioned by an unwillingness or inability to recognize that infantile sexuality really exists. The parent withholds sex information or stories of blood lest he create sex curiosity or sadistic tendencies in the child mind, which in his opinion is normally innocent of such traits. But these tendencies occur in the child spontaneously. And the rôle that fairy tales play ordinarily is not that of creating or developing such impulses, but is rather in the direction of rendering them harmless; that is to say, such stories represent an avenue for a sort of sublimation of these impulses. They provide a harmless outlet for tendencies that would otherwise have to be turned wholly against the parents or other members of the family or else have their energies wasted through succumbing to an all-too-fundamental repression. The temporary and legitimate semi-sublimated outlet which the fairy tales provide protects the energies in question from these two fates and favors the formation later of true sublimation in the form of socially legitimate and useful activities.

The cases in which one finds that the fairy tales are invested with, for example, too much sadistic feeling and form the model for sadistic phantasies are only an apparent exception to the rule that fairy tales represent a benign outlet. These cases represent instances in which the sadistic impulse, either by heredity or through previous experience, is definitely overaccentuated. The stream of feeling is so voluminous that it fills and overflows the channel of outlet. The channel is not large enough to draw off successfully such an overcharge of sadism. Those cases in which it appears as if the fairy tales had had the effect of overdeveloping sadistic tendencies are, in general, really ones in which the sadistic tendencies, overdeveloped by quite other factors, form so copious a stream that the fairy tales and similar legitimate outlets are unable to perform their usual rôle of drawing it off harmlessly and assisting sublimation.

So much for the criticism of individual chapters of the book. Despite definite shortcomings in various sections, it averages up reasonably well as a whole, and but for one reason might be spared serious criticism. This reason, it so happens, resides not so much in the book itself as in the title that the author has given it. This title *Psychoanalysis; Its Theories and Practical Application*, leads one to expect a systematic, well-rounded presentation of all the subjects which are thus implied—or, at the very least, an attempt at such presentation. The facts are that the book gives nothing of the sort and does not even attempt to. It is merely a collection of reprints having no relation at all to one another, which Dr. Brill has published in medical journals at various times over a period of some twelve or thirteen years. Had he been content with such a title as *Psychoanalytic Reprints*, one could criticize his book merely from the point of view of what it contained; but so comprehensive a title forces one to judge the book, not simply on the basis of what the author put into it, but also on that of what he left out and what should be there were it to live up to its title—and its preface. The book certainly does not live up to its title at all. The picture it gives of psychoanalysis is most imperfect, distorted, hazy, and confused. The expositions of theory are often disorderly and inadequate. As a presentation of practical application or technique, the book fails utterly, and is meanwhile misleading. A great mass of most important and vital facts concerning analysis are not only omitted from mention, but not the slightest hint is given of their existence. The serious thing is not that the book fails to live up to the promise of its title and its preface, but that through this failure it becomes misleading. It is like a tourist guide who, promising to show a visitor the city of New York, takes him only to Greenwich Village.

Let us take up the matter of technique particularly, for this is where the book most conspicuously fails. In the correct psychoanalytic practice of to-day, the analyst preserves a very passive attitude. He seeks to provoke a transference neurosis, which replaces the original neurosis for which the patient seeks treatment. The patient repeats in this new neurosis all the symptoms, past and present, of the old one, but with the analyst now occupying the rôle previously played in the original neurosis by other persons. With the analyst as a fulcrum, the patient repeats not only all his symptoms, but also all his serious conflicts; not only the conflicts of adult life, but the forgotten conflicts of childhood. All these are reënacted and lived over with full adult intensity of emotion. It is this new neurosis rather than the old that is analyzed and cured. With it cured, the old neurosis no longer exists.

As may be gathered from these statements, a psychoanalysis is not in the least like, let us say, a surgical operation, in which the patient is utterly passive and the physician does something to him. In an analysis, the patient, not the physician, is the really active one. An analysis is on the whole not an operation, performed by the doctor, but rather a *process*, which is set up in the patient and which the physician, like one tending a fire, watches, supervises, and gently guides until it burns itself out.

The physician's rôle is indeed a very passive one. The analytic technique is applied mainly for the purpose of discovering, interpreting, and rendering conscious to the patient his resistances—relatively little for the interpretation of symptoms. For, with the resistances thus dealt with in the order in which they appear, the patient discovers the meaning of the symptoms for himself; while, so long as the resistances are in force, no amount of explanation or interpretation of symptoms would ever make him see through them.

We doubt if any one would ever guess from the reading of Dr. Brill's book that such is the correct analytic procedure. The picture it suggests is a wholly different one.

As might readily be surmised from the foregoing description, the great task in an analysis is the understanding and handling of the transference. The transference and its proper management are nine-tenths of an analysis. They represent the problems that make the greatest call upon the skill of the physician. Only through the patient's reënactment, in the transference, of forgotten scenes and conflicts does one ever do away with the amnesia veiling the infantile period and thus get at the real roots of the patient's character and his neurosis and gain a clear view of the true unconscious. The understanding and handling of the series of reënactments which constitute the major part of an analysis are the most difficult and vitally important parts of the work.

Of the real nature of transference, of the problems it creates and of its significance in the analysis, Dr. Brill gives us no hint whatever. What little he says, indeed, is utterly misleading. Thus, on page 13 we read that transference is a certain "*rapport*", an understanding and liking that are established between doctor and patient. One must be on his guard, we are warned, to remain good friends only and not let the transference "*be carried too far*".

To any one who has himself lived through, or successfully guided a patient through, that long and violent storm of shifting conflict, stress, and pain, which represents the transference in most cases, Dr. Brill's definition of transference, above quoted, and his suggestion as to management seem utterly laughable. (There is very little said about transference throughout the rest of the book.) It is true that

at the beginning of an analysis, for instance, a mild positive transference may result in an attitude on the patient's part that would correspond to the rapport of which Dr. Brill speaks, and in which the analysis, the interpretation of dreams, and so forth, proceeds for a time easily and smoothly. But this peaceful period rarely lasts long. For most of the phases of transference, and especially for the most important ones, the terms "friendliness" and "rapport" are about as fitting as would be the adjective "placid" for the European War.

To sum up, then, the book is anything but a reliable introduction to psychoanalysis. Its chief merits are that it is interesting throughout and that it contains some excellent examples of exposition in those chapters in which the author makes least effort to be original. On the whole, however, the book is not to be recommended. It gives, it appears to us, a decidedly wrong slant on psychoanalysis and all too readily operates, through the very fact of being so interesting, to seduce the reader from serious study of the subject by satisfying him with entertaining, but faulty presentations. It thus serves to create and foster that superficial and rattlebrained interest in psychoanalysis which has become such a pest in this country. A book of this sort, written by an author who has come to be regarded as an authority, is deserving of serious disapproval. For such reasons we have undertaken this extensive critical review.

We feel that Dr. Brill has done himself an injustice in publishing this book. The carelessness in writing and thought that is so clearly evidenced, especially in the chapters written in more recent years, is surely responsible for serious mistakes that a little more care on his part would readily have avoided. His tendency to claim more for himself and his book than either is fully entitled to, as evidenced, on the one hand, by the selection of a title whose promise the book does not in the least fulfill and, on the other, by the omission of quotation marks from paragraph after paragraph of material taken practically word for word from Freud, creates a bad impression that is by no means wholly deserved. We feel that Dr. Brill, should he really apply himself to the task, could write an infinitely better book, one that would do real justice to his subject and to himself as well.

H. W. FRINK.

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CRIME, ITS CAUSES AND TREATMENT. By Clarence Darrow. New York: Thomas Y. Crowell Company, 1922. 292 p.

There is unfortunately a large class of publications that treat of criminological problems from the standpoint of "the outsider". The writers of many modern criminological books have themselves had

little practical experience with the problems that they discuss. They are like critical neighbors who peek in through the windows of a man's house and criticize his furniture and his daily actions on the basis of what they can see through a small and perhaps dusty window-pane. It is true that such people see more than a man who simply passes by the house and never takes the trouble to look in at all even through a windowpane. Nevertheless, they must of necessity see the things inside the house from a wrong angle and with an improper perspective. The only satisfactory method of criticism in such cases is to ring the front doorbell and ask to be shown over the house. So many writers of books on "crime" have dealt with the whole subject from the standpoint of the looking-through-the-window critic that one is delighted to come across a book that is the result of actual and practical experience with the daily problems of criminology and criminal procedure. Mr. Darrow has spent thirty or forty years in court, he is an eminent member of the bar, and is, moreover, a man of wide reading and cultivation. It is seldom that practical experience and scientific knowledge are so satisfactorily combined in one person and that a person with a trained legal mind and at the same time an intense human interest in delinquents and their lives.

It would be a work of supererogation to pick out any parts of this book as particularly stimulating, inasmuch as almost every chapter contains matter that even the experienced criminologist will find useful and suggestive. The chapter on "medical experts", brief though it is, contains an excellent statement of the difficulties that are involved in the present legal uses of so-called "expert testimony". It discusses also the possibility of having an expert appointed by the court and at the same time points out the difficulties that such an appointment would bring with it. The author looks forward to a development of criminal procedure in which "the machinery of justice will be all-sufficient to take care of the liberties of every man, to give him proper treatment in disease and to restore him to freedom when it is safe to do so. When such a time does come, the unseemly contest [between partisan experts] in the courts will disappear and justice tempered with mercy will have a chance."

Mr. Darrow's conception of life and of human personality is in a sense a purely materialistic one; it is the conception that one often met with in Europe before the war and that was associated with the legal teaching of old Professor von List. To those who have been trained in this school of thinking, the human animal is purely a result of heredity plus environment; there is no place for freedom of choice and, therefore, the real criminal is not the thief or the murderer, but rather the society that allows people with tainted past histories to beget large families and that permits their children to grow up in

environments that will lead with a mathematical certainty to crime and delinquency. The criminal is, therefore, not to blame for his breach of the law; he is a sick man—a weaker brother who has never had the opportunities for education or development that have been accorded to his more fortunate fellows or who has inherited—through the operation of laws the details of which are still unknown to us—a twisted mental or physical make-up or an actual mental deficiency.

Granted the principles of such a philosophy, there is, of course, no place for punishment in the scheme of the criminal law, neither can the penalties of the law ever act as deterrents, inasmuch as crime results with mathematical certainty in each individual case from a bad environment reacting on a bad heredity. Prisons of the old type are, therefore, not only anachronisms, but engines of inhuman cruelty. The ideal of the criminologist will find its only adequate expression in some such law or ordinance as that which has been of late at least proposed, if not actually enacted, in Prague for the republic of Czechoslovakia. According to this law, social hospitals are to take the place of prisons. Each offender is to be classified after complete physical and mental examination and is to be assigned on an indeterminate sentence to that social hospital that most closely fits his needs and his antisocial tendencies.

The deputy who introduced this law boasted that it would absolutely eradicate crime within a generation. There are, however, many of us who are brought day by day into contact with the dull routine of delinquency who do not look at the problems of criminology exactly along these lines. We are more in sympathy with the way in which Englishmen and English lawyers look at these same problems. We feel, many of us, that capital punishment, for instance, is a deterrent and about the only deterrent that is really feared by an antisocial personality. We have seen the good results of punishment, but punishment of an enlightened, developing type that is closely associated with mercy and long-suffering. We are inclined to treat the delinquent rather as a badly brought up, undisciplined child than as a sick man who cannot help being sick and who can make no effort to free himself from his trouble.

Mr. Darrow says (p. 57) in speaking of the criminal: "He is seldom a man of average intelligence. . . . *Almost always* he is below the normal of intelligence and in perhaps half of the cases very much below." This statement is not borne out by the investigations that have been made both by Dr. Adler, State Criminologist of Illinois, and by other equally prominent psychiatrists. Ten or more years ago, when mental tests were first being introduced and the populations of various penitentiaries were being mentally tested, many investigators seem to have discovered a very high percentage of

mentally deficient persons among the imprisoned delinquents. At once, people believed that mental deficiency was probably the real cause of crime. It was not until after the war, or until we had studied the results of the mental tests given to the drafted men of the American army, that we realized how wrong such a conclusion was. We found that the population of the average penitentiary was a very fair reflection of the extramural population. There were no more mental deficient and morons inside the walls than there were outside. Indeed in some cases the mental level of the prison was somewhat higher than that of other institutions that contained no actual delinquents. Mr. Darrow ought, therefore, to modify the statements that I have quoted, as they give the reader rather a false idea of the actual situation.

It is rather a thankless task, however, to criticize in detail a book that contains so much that is interesting and of value. It is written clearly, evenly, without a tremendous mass of scientific terminology that might frighten away the average reader. Mr. Darrow is entitled to our thanks for what he has done, and the reading public, whose only source of knowledge of these matters is the daily press, would do well to put down for a few minutes the newspaper accounts of the latest murder and to take up Mr. Darrow's book as a helpful antidote and a source of valuable information.

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YOUR INNER SELF. By Louis E. Bisch, M.D. New York: Doubleday, Page, and Company, 1922. 195 p.

The publication of this volume adds another to the rapidly filling shelves of popular literature on psychoanalysis. Dr. William A. White gives a kindly foreword. The text is logically arranged and easy to read. By a telescoping process at times disastrous to clarity, the whole Freudian system, from infantile sexuality to interpretation of religion and art, has been condensed to fill less than two hundred pages. Quotations are freely made from other writers, and examples from the author's practice are used to illustrate certain mechanisms. Crude sex material is handled boldly, but, with the possible exception of homosexuality, in a manner to give rise to a minimum of offense and misunderstanding.

The reader may obtain a superficial orientation toward the terminology and general facts of psychoanalysis from reading this book. It offers, however, a primer type of instruction and lacks that presentation of the deeper principles of genetic psychology which would seem to be of more value to the laity than so many details.

Certain statements are misleading and, if representing anything more than illustrative hypotheses, are quite unsound. Examples are as follows: On page 7 one finds the statement: "The mind, in its infinite variety, is indeed a complicated mechanism. Yet it is a machine, like any other organ of the body, and its workings can be studied." On the same page one reads: "Just as the brain cells manufacture thoughts, so do the liver cells manufacture bile and store up sugar in the form of glucose."

Brevity in treatment is always welcome, but it has disadvantages. In considering the sex hygiene of the child, the author states (p. 32): "Information on sex matters should be given by the parents simply, truthfully, and fully." With this platitudinous comment, the topic is dismissed.

Introversion and extroversion are discussed in Chapter VI in a manner to cause the average reader to view with unnecessary alarm any evidence of the former tendency in himself. In dealing with the psychoses, lamentable opportunity is given for misinterpretation. On page 4 there is a description of what might easily be understood as a case of obsessive thinking, familiar enough in the psychoneuroses. The following comment is made: "In her case, consciousness had lost the power of submerging ideas quickly. This woman was developing a mental illness." On page 32 one is told: "The saddest mental disease of all is dementia praecox. . . . Seclusive, erratic, day-dreaming children should always be suspected." One can imagine the consternation that such obscure wording might produce in the mind of an apprehensive reader.

In Chapter XII, some unwarranted distinctions are drawn between the neuroses and the psychoses. On page 152 the author states: "The neurotic turns one way and the psychotic the other. The neurotic does not retrace his steps and follow the other road. So also does the psychotic travel his own course. That is why a neurotic need not fear a psychosis."

The following unqualified statement (p. 153) on dementia praecox is inexcusable in the year 1922: "Dementia praecox is the quintessence of introversion. The patients have completely severed normal relationships with the world about them, an impassable gulf separates them from everybody and everything. . . . The patients live within themselves and their interest in outside affairs cannot be aroused. Their adjustment within themselves is so perfect that, once established, it cannot be broken up."

The reviewer hesitates to recommend this book for the popular consumption for which it was written.

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ENGLISH PRISONS TO-DAY: BEING THE REPORT OF THE PRISON SYSTEM INQUIRY COMMITTEE. Edited by Stephen Hobhouse, M.A., and A. Fenner Brockway. London, New York, and Bombay: Longmans, Green, and Company, 1922. 728 p.

A galaxy of stars, including Bernard Shaw, Sidney and Beatrice Webb, Stephen Hobhouse, and A. Fenner Brockway, have lately been shedding their light on the English prison system. *English Prisons under Local Government*, a history of English prison administration by the Webbs, with a preface on the theory of punishment by Shaw, is published simultaneously with *English Prisons To-day*, which is a descriptive account of existing conditions. This work is not only edited, but largely written by two gentlemen who add to the natural advantages of being university men and of having well-developed hearts and souls as well as minds and brains, the expert knowledge of their subject that is derived from having served prison sentences during the war as conscientious objectors.

The enormous amount of material collected by the committee of which Sir Sydney Olivier was chairman is presented in this huge blue tome with a masterly handling that makes the book a model work of its kind. It has been the subject of numerous and exhaustive reviews in both general and technical periodicals since it appeared in the summer of 1922, and rather than contribute another to these all-around reviews, it would seem more profitable to utilize our allotted space with a consideration of the chapters on the mental aspects of imprisonment, as indicated by the investigations of this committee. Among the titles of the thirty-eight chapters are *The Mentally Deficient*, *Insanity among Prisoners*, *Suicide and Attempted Suicide*, and *Specific Causes of Deterioration*.

The English experience in connection with mental defect seems similar to that of this country. The admirable "Mental Deficiency Act", which went into operation in 1913, five years after the appointment of the Royal Commission on the Feeble-Minded, as a result of its work and recommendations, gives the Home Secretary the power to transfer to an institution for mental defectives any prisoner certified by two medical practitioners to be mentally deficient from birth or early age, but only about one-third of this class of defectives are certifiable for such transfer, and therefore two-thirds of those who are sent to prison are still legally condemned to remain there. The unsuitability of prison life and discipline for such cases has been well and amply proved, and is sufficiently known in this country, where conditions are very much the same.

Insanity is estimated on careful figures as 86.6 per 10,000 among prisoners, and after deducting the cases considered mentally unsound

upon reception, the ratio is 41.3 per 10,000, which is nearly five times as great as the rate prevailing during the same period (1906-1915) among the ordinary population. It is significant that the ratio of insanity to the number of sentences increases markedly with the length of the sentence imposed. While in sentences under one month the certified insane number fewer than 1 per 10,000, at three months they number 7 per 10,000, while twelve-months prisoners show a ratio of 40 per 10,000, those sentenced to two years' imprisonment have a ratio nearly three times as large, and five-year convicts nearly nine times as large.

The figures for suicide are striking. Notwithstanding the elaborate precautions that are taken to prevent suicide in prison, the death rate from suicide for the period of 1886 to 1909, which was 17 per 1,000 in the general population, was 73 per 1,000, or more than four times as great, among prisoners. During the past twenty years the number of actual suicides has almost doubled, whilst the genuine attempts reported have more than doubled, and those classified as "feigned attempts"—which, as is well said, might better be described as "half-hearted"—have increased very considerably.

The chapter entitled *Specific Causes of Deterioration* begins with this significant sentence: "In general the effects of imprisonment are of the nature of a progressive weakening of the mental powers and of a deterioration of the character in a way which renders the prisoner less fit for useful social life, more predisposed to crime, and in consequence more liable to reconviction." What an arraignment! And yet it is hardly credible that any one not hopelessly blinded by prejudice could read this volume and fail to see that this is a moderate statement of the actual facts. Specific features which are primarily responsible for these obviously undesirable results are admirably summarized in the following paragraph: "The system operates almost entirely without the direct infliction of physical injury or bodily pain. Its essential nature lies in the systematic denial of liberty and of such activities as are not absolutely essential to the barest existence. The problem for its inventors has been to devise a method of punishment embodying their conception of the primary importance of retribution and deterrence which would be applicable to every class of offender. The mere denial of luxuries would be inadequate in view of the numerous individuals among those committed to prison by the courts whose lives are normally so wretched as to render the withholding of luxury no additional burden. This difficulty is overcome by a régime of punishment, the essentials of which comprise the denials of those activities and rights shared by all, even the most needy. The chief of these common activities of

man are speech and association with others, choice and self-direction in the actions of daily life, and self-expression in the arts and crafts of hand and brain. The prison system operates by forbidding speech, restricting association within the most inadequate limits, abrogating by rigorous supervision all choice and self-direction, and depriving the individual of almost all facilities for self-expression, prison labor being as far as possible lacking in interest or refining qualities."

It would appear from this book that methods of prison discipline are based on the homeopathic dictum "*similia similibus curantur*". If a man is afflicted with an antisocial trend, remove him from all social life so that solitary confinement may socialize him! Even in prison correct medical practice probably does not include bleeding as the treatment indicated for anæmia, but this principle, driven from the physiological field, maintains a last stand in the psychological. As one witness expresses it, "When one is going mad through the solitude and silence, to be put under observation and given *more* of the solitude and silence is like the last straw."

One of the ingenuous devices designed by the lay mind for detecting malingering seems based on the logic that served our ancestors so well in determining the status of the witch by drowning. A suspect is enclosed in an apparatus described as resembling "a huge glass coffin" and subjected to "a shower bath without end". The shammer under these conditions will confess after the first five minutes, during which the treatment becomes unbearable, but the true psychotic will "stand or collapse".

The writers point out that the mental effects of imprisonment are, broadly speaking, of two kinds—failure and success in adaptation, which are described as follows: "Failure in adaptation to prison conditions is evidenced by mental aberration, of which insanity or nervous breakdown produced by the stress of prison conditions is an extreme example. Other examples, the pathological nature of which is frequently misunderstood by prison officials, are nervous irritability, a heightened disposition to emotional reactions, morbid fancies, and delusions of persecution. Conversely, atrophy of the powers of mind and condition of listlessness are changes in the prisoner's mental life which place the prisoner more in harmony with his environment, and diminish the sufferings that arise from unsatisfied desires. Complete apathy, therefore, is the most perfect form of adaptation."

Is the popular mind conceivably sane that can create an institution for the benefit of society where the individuals for whom it is designed are suspended between the horns of the dilemma represented at their extremities by mental aberration and mental deterioration? Adapta-

tion here seems to be a case of "You're damned if you do and you're damned if you don't."

Is it not time that mental hygienists had something to say about these conditions to which human beings are subjected? A revelation of physical atrocities in any institution or group of institutions would call forth violent protest from the medical profession as well as from laymen, for all can understand physical torture. But cannot all understand to some degree mental torture? And having discovered the place where it is in active operation, not as an accident, but as an accepted system of treatment, can we go on countenancing its infliction? Is there not a minimum requirement of mental as of physical life that should be demanded by the public in general and by the medical profession in particular? The conclusion that is forced on the reader of this book is that while physical injury and starvation are regulated and to some extent prevented by medical supervision and the acceptance of medical authority as final in matters of corporal punishment, reduction of diet, and other details of life and discipline, mental injury and starvation are not only not regulated by medical or any other authority, but are utilized to a degree that is appalling and disastrous even to the supposed aims of imprisonment. Has not the time come when public opinion would support a demand for scientific regulation of the mental as well as of the physical life of the prisoner, a regulation aimed to prevent the injury of the mind to the point of rendering normal life in or out of prison impossible? If corporal punishment and deprivation of food are resorted to at all as disciplinary measures in institutions that conform to decent standards, they are permitted only on medical orders and under professional observation. Such opinion is final as to how long an individual prisoner can safely exist on a bread-and-water diet. But how about a mental diet of solitary confinement? Who determines how long the mind of a prisoner can be subjected to that ordeal without serious and irreparable impairment?

In the masterly final chapter of this book, in a section significantly entitled *Physical Pain Replaced by Mental*, the situation is summarized as follows: "Stated in physiological terms, primitive forms of punishment consisted in the infliction of gross bodily hurt; modern penal methods are directed upon the higher functions of the central nervous system."

The American reader cannot comfort himself with the delusion that we manage these things better in this country. The writers sagely remark, in their appendix *Some American Experiments*, that if they were attempting to describe or criticize American prisons as a whole, they would "have to point out that America is in some respects

behind other civilized countries, that many of her arrangements for the custody of prisoners are deplorable, and that some of the influences and movements here described have not yet penetrated or extended very far". The lesson of the American experience is summarized in this quotation: "Unless a prison is curative and makes a man better, so that when he goes out, he will see things from a different standpoint, it has no more right to exist than a hospital that would maim and cripple its patients and send them out a greater burden on the community than when admitted."

MARY VIDA CLARK.

New York City.

DREAMS AND THE UNCONSCIOUS: AN INTRODUCTION TO THE STUDY OF PSYCHOANALYSIS. By C. W. Valentine. New York: The Macmillan Company, 1922. 143 p.

This is another "introduction" to psychoanalysis that does not introduce. As a discussion of certain psychoanalytical material and principles, it is written with an unusual simplicity and clarity; much of it is ably done. But it remains a discussion of Valentine's views of certain psychoanalytical principles, with his modifications and reservations, rather than an elucidation of those principles themselves. Such discussions are necessary and, when those who discuss are properly prepared, are helpful, but they can hardly be considered as "introductions". Professor Valentine's modifications (the author is professor of education in the University of Birmingham) would seem, furthermore, to be due not only to a lack of full understanding, but to a misunderstanding of the real significance of some of the things he is trying to elucidate. His discussion leads one to believe that he has been unable to "follow through"—thus far, good; but let's go no further. As one might become interested in chemistry—might read a bit, experiment a bit, might even be thrilled as its possibilities unrolled—and then, finding that chemistry deals with unpleasant as well as pleasant material, might argue that it would be better for all concerned if chemists confined themselves to pleasant things—that H_2S belongs in the sewer, not in a chemical laboratory. One would, of course, miss the point: that H_2S is just as "clean" a chemical as any other; that there is nothing inherently "wrong" about H_2S ; that it has great value and usefulness and that the world would be poorer without it; that one does not serve it at tea parties, but that those at the tea party would be better men and women if they had come into some intelligent contact with H_2S and had learned its true significance and the part it plays in the world. One who

stops his study of chemistry at the first whiff of H_2S can never claim to understand chemistry.

Aside from these more fundamental matters, one notes some points that, while minor, are important gauges of the extent to which things have been thought through. Professor Valentine is disturbed by the fact that psychoanalytic data come so largely from the analysis of neurotic individuals; he still seems to regard the neurotic patient as somehow "different" from other persons. Such "difference" as there may be is, of course, one of degree, not of kind. When one studies an element in the illness of a neurotic patient, one does not study something that is "different", but a something that has been simplified—that, disentangled from the complexity of its usual setting, stands out nakedly in relief where it can be studied. It would be difficult to study the bony structure of a fat man; easier on a thin man; easier still on a starved one; easiest on a skeleton. But it would all be a study of bones. A similar situation exists in physiology, where most, if not all, of the knowledge that we apply in the understanding of one individual has come from a study of the pathology of other individuals as found in hospitals or as induced in the laboratory. Professor Valentine no doubt finds in his own field that by studying the failures of some of his students he learns much concerning the success of others. This is a point hardly worth discussion were it not for the fact that many find it a difficult hazard. That a professor of education should rein up in front of it is not surprising, for we have seen physicians who, although that very day they had been applying the knowledge they had gained in the autopsy room and the pathological laboratory to the understanding of an individual to whom they were giving a "health" examination, reined in their thought before the same hazard.

"We know that in many cases there may be great severity on the part of parents without any apparent nervous weakness in the child afterwards. The history of Puritanism could probably supply thousands of such cases", says Professor Valentine. There must, indeed, have been thousands of Puritan children who were not driven into psychoses or neuroses by the severity of their parents. But is that all that Professor Valentine sees in the matter?

What would seem to be a complete lack of understanding of the significance of this process and what is to be expected from it leads him to a statement still more extraordinary:

"Furthermore, the physical and mental health of the child is not the sole aim we must keep in view. It may be that it would be worth while to sacrifice this to some extent, if necessary, for the sake of

moral training and a conformity to what is found needful for the well-being of society as a whole."

If only we knew what is "needful"! Is the choice between "health" and "disease"? Who is to decide what is "needful for the well-being of society as a whole"? The "normal" and "healthy"? But who are they? At what degree of ill-health does one finally cease to be "healthy" at all and pass over into the disease group? It is foolish to talk of "disease" and "health" as if they lived on different streets or even in different apartment houses on the same street. What degree of "health" has one who will say, "For the sake of his 'moral training' and to make him 'conform'" (to what? determined by whom? the state of that person's "health"? "we will sacrifice this child's physical health or his mental health"? Aside from the perplexity of deciding to what he shall conform—Professor Valentine's code, your code, my code, the "mass" code?—what is the "moral training" or the conformity worth under such circumstances? Furthermore, if the child will not conform, why stop at such weak-kneed efforts as spoiling his health? Why not put him out of the way, not gently in prison, but with chloroform or rat poison? The principle is the same.

Shall we learn what is "needful" for society *as a whole* by any such method? Since our knowledge of what is "needful" is still so limited, would it not be better, instead of adding force to *make* individuals "conform", to continue our studies of *why* they do not "conform". In Cleveland it was found that many children did not "conform" (in the sense that they did not learn their school lessons well) because their bodies lacked a sufficient amount of iodine. The deficiency of the local water supply is now made up by administering iodides to these children, and it is found that they "conform" much more easily. It would have been unfortunate to have passed out the rat poison before this fact was discovered—even to have "sacrificed to some extent the physical and mental health" of these children "for the sake of moral training and conformity". Sometimes the *why* is purely psychological instead of physical. It matters not; the question is the *why*. Strangely enough, sometimes those who do not conform are found to be right and those who would *make* them conform to be wrong. There are so many codes, and so frequently the codes are codes of personal necessity rather than general necessity, although the individual is not likely to make the distinction. For the present, it would seem better to continue the studies of *why*. We will make greater haste in finding out what is "needful" by this slower method.

But, after all, this review gives hardly a fair estimate of Professor

Valentine's book. It is a much better book than one might gather from this discussion of it. I have chosen to discuss these matters because they are quite too important to be overlooked, but nevertheless the book is ably done in many respects and will be found useful.

FRANKWOOD E. WILLIAMS.

The National Committee for Mental Hygiene.

REPORT OF THE CONSULTANTS ON HOSPITALIZATION APPOINTED BY THE SECRETARY OF THE TREASURY. Washington: Government Printing Office, 1923. 112 p.

This is an account of the most important project in hospital development for mental diseases in some time, ranking with that of the New York Hospital Development Commission. Additional beds must be secured at frequent intervals in most of the states and many hospital heads have definite ideas about the lines along which their own institutions should develop, but such plans are for individual institutions. New York is not the only state in which central authority has laid plans for new buildings looking some distance into the future, but New York has so many more patients than other states that its plans are on a larger scope. The development of hospitals for the federal government involves so much vaster territory and so many local factors as to be a very complex problem and several brand-new institutions were required in addition to an increase in the size of existent ones and the remodeling of a number of buildings that were erected for other purposes, but that lend themselves with more or less facility to the care of mental patients.

The report covers events from October, 1917, when an amendment to the War Risk Act provided that disabled ex-service men might be hospitalized, to February 26, 1923, when the last 200 beds for tuberculous cases were transferred by the Treasury Department to the Veterans' Bureau. The members of the committee that makes the report were appointed by the Secretary of the Treasury as Consultants on Hospitalization. Public Act No. 384, approved by President Wilson on the last day of his official career, had devolved on the incoming Secretary of the Treasury the duty of providing these hospitals, and Secretary Mellon appointed as his consultants Dr. William Charles White of Pittsburgh, Dr. Frank Billings of Chicago, Dr. John G. Bowman of Pittsburgh, and Dr. Pearce Bailey of New York. Dr. Bailey was succeeded by Dr. George H. Kirby of New York.

The consultants lost no time in beginning their work, holding their first meeting March 16, 1921. They are generous in awarding praise to various public men and agencies and are not disposed to chant their own merits. They remark that the hospitalization of disabled veterans

was a task that had never been attempted by any government before, so there was no experience in all history that could serve as a guide either to Congress or to the administration to assist in determining the extent of preparation necessary to execute the law. The Treasury Department, the Veterans' Bureau, the beneficiaries of the government, and the people at large are more indebted to this board than will soon be recognized. It is probable that experience will show some defects in their plans and some errors in execution; this would be inevitable. But the fact stands out that they went about their enormous task with great vigor, made use of actuarial figures to determine the probable number of cases to be cared for, and tried earnestly and intelligently to place hospital facilities within reach of the men who would need them.

On page 10 of the report is a statement of fundamental principles which should—and in part largely did—determine the creation of hospitals. Existent government hospitals under control of the various agencies and accessory facilities in state, municipal, and private institutions were listed and charted. Railroad facilities, the number and distribution of ex-service men in various localities, the nursing and medical facilities of the various sections of the country, and the ebb and flow of the sick—particularly the tuberculous, who travel in search of desirable climatic and hospital facilities—are closely related matters. The relation between the hospitals now being used and the existing soldiers' homes was considered, as well as the possibility of the conversion of some of these hospitals later into institutions for domiciliary care. Such a study could not progress far without some reference to the various ways in which governmental agencies have bungled or are likely to, and one of the lessons to draw from a report of this sort is the tremendous importance of avoiding errors that are not difficult to see if one will but study what our governmental agencies have done in other periods. It is too much to expect that those in authority will always be men of the highest wisdom, and our governmental machinery is so complex that a perfectly well-intentioned official whose field is rather on the outskirts of the hospitalization problem may block the progress of an important project because it seems to him to infringe on other projects which he comprehends much better because they are within his immediate field.

The consultants shortly summoned an advisory committee, including representatives of several bureaus and services already responsible in various ways for the care of the disabled veteran, army and navy officials, and representatives of the great national public-health organization. Expert reports on various matters were obtained, of which an excellent instance is a study of psychoneurotics who were being harmed by hospitalization. Methods of securing an adequate

personnel were studied. We have no doubt that the influence of this committee was one of the factors that led to the retaining of a large number of psychiatrists as reserve officers in the Public Health Service, and to the other types of contract by which medical personnel could be recruited. That the problems of personnel are not altogether in a satisfactory state is indicated by a recommendation on page 15 that further study be made by the Federal Board of Hospitalization and that standards be offered for government guidance. The committee were evidently opposed to a centralization of medical service, and the course of events has sustained their judgment.

"The only field", the report says, "in which standardization was accomplished was in hospital plans." This is a subject always of great importance and especially in this period when the need of 15,000 additional hospital beds for mental cases in this country is forcing itself on the attention of administrators, legislators, and a considerable section of intelligent public opinion. The consultants state that a request was made that a medical director for each institution be chosen during the process of construction; this subject is so enormously important that it deserves a much more extended consideration than can be given it in this short review. It is an unfortunate tendency in this country, when a new institution is established, to put up the buildings first and than seek a man to operate them. A striking exception was the development of the Phipps Clinic of Johns Hopkins University. The medical director was appointed and given facilities for spending months in determining every detail of the plans before a contract was let or the personnel engaged. Results have, of course, justified that policy.

The consultants seem to be pleased with the outcome of their attack on the planning of institutions and say definitely: "An inspection of a number of the finished hospitals by members of the consultants' staff has led to the conclusion that there is nothing better in the United States, and probably in the world, in the way of hospitals fitted for the special care of disabled veterans suffering from tuberculosis and nervous and mental diseases than those which have resulted from the expenditure of the moneys under this act." One may agree in general with this dictum and yet be strongly of the opinion that closer coöperation between the office of the supervising architect of the Treasury Department and the office of the consultants might have been beneficial. It is unfortunately the practice of some officials to take the bits in the architectural teeth and gallop madly over the grounds of a new hospital, throwing up a pile of stone here and a mound of brick there, getting results that are perhaps pleasant to look at, but that may overemphasize the institutional aspect of the place, and occasionally planning features that mean inconveniences in

operation little short of tragedy. We do not assert that the completed buildings in these hospitals are not better than many in other hospitals, but a careful study of certain buildings, particularly the so-called diagnostic group, convinces us that the layout is not by any means ideally convenient for operation. For example, corridors tend to be long and gloomy and dispensary facilities are not well located. It is true, as recently stated in the *Architectural Forum*, relative to hospitals for mental cases, "such hospitals have not been standardized to the same extent as other types, and it is difficult to find many good examples". It is suspected that the architect of these hospitals for veterans would have done well not to have stopped with the advice given in a preliminary memorandum; it would probably have been possible to pass plans back and forth between the consultants and the draftsmen until arrangements as near as possible to perfection had been reached.

It is easy to carp at floor plans, but the writer knows by experience that it is difficult to draft floor plans that will prove entirely satisfactory when the building is constructed. Therefore, not too much should be said about wards that look somewhat gloomy, about swimming pools, and about compelling senior medical officers to dine in their living rooms. No one can study the plans of these buildings without realizing that much thought has been put upon them. The buildings for tuberculous patients particularly seem quite in line with the most advanced opinion on suitable construction for such cases. The work had to be done as quickly as possible in a period when building costs were high. Though it is not so stated in this report, it is understood that plans were skimped now and then, because even the liberal appropriations made by Congress did not prove sufficiently large to accomplish all the things needed. There were evidently at various points of this proceeding differences of opinion with the Veterans' Bureau.

Some hopes have not yet been fulfilled. The Bronx hospital, for instance, was expected to comprise 1,000 beds within ten months from September, 1921; it still has less than half that number at the end of March, 1923. Queries are already raised as to why 1,000 cases should be located on this little plot of ground close to a thickly settled apartment-house district, but the consultants point out that their plan was to provide for various types of cases there and not merely mental patients. The cost of building and equipment ranged from \$1,861 to about \$5,000 per bed, but even so some of the equipment came from surplus supplies on hand and some from an allotment to the bureau of supplies. The consultants point out that where an institution had to be planned entirely new, the cost per bed was of course much greater than when mere additions were made. The consultants were

impressed by the value that would be derived from having data on comparison of costs in various institutions, and they publish a scheme for such a determination. It is to be hoped that this will be prepared and made accessible to states and municipalities also. This is somewhat in line with the recommendation that the present board of hospitalization be continued in some form. The plan is probably sound, but it is certainly to be hoped that any board of hospitalization that deals with veterans will have a more sympathetic and intelligent attitude toward some of the problems involved than has been the case during the last two years.

In one regard we believe that the estimates of the consultants are seriously in error. In January, 1922, they estimated that the number of beds needed for neuropsychiatric cases would be 8,000. In the next month a conference of psychiatrists was called by the Veterans' Bureau and decided on the basis of the best figures available that approximately 12,000 beds should be provided for neuropsychiatric cases. There seems to be no good reason for accepting the lower estimate. On March 8, 1923, the number of cases accepted for hospitalization was 9,311 and the peak of the load is some time ahead. Unless the government proceeds with an ample program of construction, there will be nothing for it but to continue the present contract system. Perhaps this is not the place to enter into a long discussion of that system. Suffice it to say that it is not satisfactory either to the friends of patients (as represented, for instance, by the American Legion) or to the public institutions that care for these cases under contract. Another unfortunate feature of the report is the suggestion that beds vacated by deaths in the National Soldiers' Homes be utilized for mental patients. No class of patient requires more highly specialized care. The mere provision of beds for them, without the special equipment and the trained personnel that their treatment demands, is an utterly inadequate handling of their problem.¹

The committee makes eight definite recommendations for future federal hospitalization, placing them at the beginning of this report, doubtless with the hope that even the most cursory reader will catch them. Several deal with the desirability of continuous study of the problems of hospitals, a matter that is of very great importance and should not be left so generally to private initiative as is the case at present. Future uses of these hospitals, when they have served their present purpose, are sagely suggested. The viciousness of individual or local interest in the location and enlargement of hospitals is touched on briefly. This reference is particularly timely, since it is generally believed that a large part of the time and work of the new director

¹ For a further discussion of these features of the report, see page 437 of this issue of *MENTAL HYGIENE*.

of the Veterans' Bureau will be absorbed in a struggle to remove the political influences that now curse it.

Let it be said again that this report covers a project of great importance. It is well drawn up, its statements clear and in admirable diction, and its illustrations numerous and well executed.

SAMUEL W. HAMILTON.

The National Committee for Mental Hygiene.

ABNORMAL BEHAVIOR; PITFALLS OF OUR MINDS; AN INTRODUCTION TO THE STUDY OF ABNORMAL AND ANTISOCIAL BEHAVIOR. By I. J. Sands and Phyllis Blanchard. New York: Moffat, Yard, and Company, 1923. 482 p.

In the authors' introduction, they state: "We have undoubtedly reached that stage when students who expect to enter some profession which involves the intimate dealing with human individuals need some such general discussion as a classroom text and as a guide to further reading. But it is our hope this book may serve a broader purpose than this in being sufficiently non-technical to be intelligible to the lay reader who wishes to gain some insight into the subject of conduct disorders." We trust that the hopes of the authors will find gratification in a wide circulation amongst the kind of readers whom they desire to reach, especially laymen, for the book will no doubt serve to set such readers straight on many subjects treated of in the text. Both authors are well equipped by experience to write on this subject.

The first chapter, which is very well written, introduces the reader, in a non-technical manner, to the theories of McDougall, Thorndike, Watson, and others. A small, but well-chosen bibliography is appended.

Chapter two is entitled *Emotional Conflicts in the Causation of Conduct Disorders*. Actual cases are brought in by way of illustration. One could wish that this chapter were longer.

Chapter three discusses intellectual capacities and their relation to behavior. A point is made of the dangers that may arise in attempting to measure the mind with a yardstick. The authors also point out the fact that low intelligence in itself is not always the explanation of delinquency. The need for a proper training of high-grade defectives, rather than for their institutional care, is stressed.

Chapter four treats of the physical basis for behavior and the influence of somatic diseases upon conduct. It is strange that the authors refer the subject of syphilis to another chapter instead of treating it at considerable length here. We do learn, however, that

"food is taken into the mouth, where it is broken up into smaller particles by the teeth". Not very profound, perhaps, but this is only as an introduction to the authors' remarks about the theories of Cotton and others. No names are mentioned, but we take it that this is the reference here since later in the same chapter the large intestine is mentioned. At any rate we find the authors disagreeing with these theories, stating that "their claim is not substantiated by other workers in psychiatry". Undoubtedly the majority will agree with this. A list for supplementary reading is appended, as to all the other chapters. One would expect to find some reference here to Cotton's work. Conservation is reflected in the paragraphs on the endocrines.

Chapter five is thoroughly well written and is worth reading by any one. It is altogether too short, but the authors' purpose is no doubt well carried out: The chapter deals with the relationship of personality types to behavior. The various personality types are described and outlines to serve as guides to their study are included, such as the Hoch-Amsden, the Wells, and the Allport. It is encouraging that the authors take a not altogether fatalistic attitude toward the possibility of changing the personality make-up.

The publishers state, by way of advertisement, that Doctors Blanchard and Sands have written their book in a sufficiently elementary style to serve as an introduction to abnormal and social behavior for the student of medicine and psychology, the judge, the psychiatric social worker, the probation officer, the parent, and the teacher. The reviewer hopes that the book will find its way to the libraries of many of these, and particularly that many judges will read the last paragraph of chapter six, which is entitled *The Rôle of the Psychoses in the Causation of Antisocial Conduct*. This paragraph reads: "The authors have met too many so-called examiners in lunacy whose sole qualification for deciding questions bearing upon a patient's commitment to a state hospital, etc., was a period of three years elapsing from the date of their graduation from medical school to the time when they applied to a court of record for appointment as examiner in lunacy. Many of these so-called examiners in lunacy openly confess ignorance of the finer points of psychiatry which are so essential for the determination between normal and psychotic states. Furthermore, it is the belief of the authors that kinship to a judge or political leader, or affiliation with a political organization, are, by themselves, insufficient qualifications for a physician to serve as a medical member of a commission appointed for the determination of the sanity of an individual charged with a felony."

This brings us to chapter seven, which deals with the border-line mental disorders as causes of abnormal conduct. Here the psychoneuroses, the neuroses, the pathological personality types, and the

border-line mental defects are described. The various theories of causation of the psychoneuroses and neuroses are discussed, the Freudian classification and interpretation are briefly described, and other theories are considered. Many things that are said in this chapter relative to the practice of psychoanalysis we trust may sink deeply into the minds of its readers. Perhaps an altogether wrong impression is given in some places as to the ease with which an analysis is made, but this is offset by the common-sense discussion of the question as to who are properly qualified to conduct an analysis.

A page or so of this chapter is given to the question of masturbation. Many sensible things are said in a few words on this topic, yet it would seem that the authors have perhaps gone from one extreme to the other in treating it. One could hardly do full justice to this topic in a page, however, and no doubt the authors' message has been effectually conveyed.

Chapter eight is headed, *Epileptic Manifestations in Behavior Difficulties*. The various conceptions of the epileptic are interestingly discussed both as to classification and causation, and there is a brief sketch of the epileptic personality as described by Dr. L. Pierce Clark. Finally we are told of the "modern management of epileptics". We are left rather in the dark as to exactly what this "management" is. We notice, however, that for supplementary reading we are referred to an article on luminal by one of the authors.

Chapter nine deals with the problem of drug addiction. This subject is pretty well discussed, on the whole, so far as the limits of the work permit. We are glad to see the dangers of veronal brought to the attention of readers. Those who have a wide experience with drug addicts will confirm what is said on this point. It is certainly a dangerous drug to put in the hands of a neurotic or, in fact, to allow to go over the drug counter without a prescription.

We can by no means agree with the remarks on the morphine habit on page 295, where it is stated that "two or three doses are sufficient to establish the habit". Such teaching as this might result in some harm, yet perhaps it is better to overstress the dangers of the drug than to underestimate them. Much that is said about alcohol and prohibition is no doubt true. The projection mechanism that is manifested in some reformers is well described. There is much that would be comforting to those who wish a change in the prohibition laws. Very much is left unsaid, however, as to the favorable results of prohibition.

Chapter ten deals with suicide, under the heading, *The Unbiological Behavior of the Suicide*. Many interesting tables and analyses are included.

There is good sense in chapters eleven, twelve, and thirteen, which

are entitled, respectively, *Educational Maladjustments*, *Vocational and Industrial Maladjustments*, and *The Modern Method for the Prevention and Correction of Conduct Disorders*.

STEPHEN P. JEWETT.

Bureau of Children's Guidance, New York City.

THE MEXICAN MIND. By Wallace Thompson. Boston: Little, Brown, and Company, 1922. 303 p.

This is not such an exposition of the mental traits of the Mexican as the title of the book would lead one to expect. The author implies in the preface that the book was written to meet the one serious criticism of his earlier book, *The People of Mexico*. Critics found it a "failure to delineate a solution for the difficulties which were described". This solution, he says, is "the education of the Mexican mass". The present work is, therefore, rather a sociological study of the people of Mexico and an attempt to forecast their future development than a treatise on the psychology of the Mexican. It is apparently the work of a sincere student and an accurate observer of Mexican life.

The dominance of the Indian mind in Mexico is properly emphasized. Of the fifteen million population, six million are pure Indians, eight million are *mestizos*, or half-caste Indians and Spaniard (two-thirds of these are dominantly Indian, both in physical type and mental make-up), and only one million are creoles or of pure white blood.

The political organization found by the Spaniards was a very primitive and ill-organized feudalism. The easy life in the tropics made clan discipline very ineffective. The outcast could easily live on the products of the jungle. The Spaniard accepted and elaborated the clan system. The Mexican is still accustomed to the local chief. In the eight hundred revolutions that have occurred in a century of Mexican independence, each has been the rising of one chief against others. The communistic trend of the constitution of 1917 Mr. Wallace regards as a very artificial graft.

As to the mind of the Mexican, the author agrees with Alexander von Humboldt that no race is more destitute of imagination, that they are imitative in a high degree and have skill in the purely mechanical arts. He insists also that "sex expressions are the end of life for the average Mexican, particularly the average male Mexican. His mind dwells ever on sex, and what corresponds to his imagination is devoted—all of it—to sex gratification." (p. 153.) There is an absence of the higher sentiments connected with courtship and marriage. There is a concentration of the mind upon lust. It is a factor

even in the frequent revolutions. Hunger, however, is the first motive force that leads the peon to join the bandit chief. Most of the soldiers are sixteen-year-old boys, or men of fifty or over. The boys join the armed bands, first, to secure food and then "for the privilege of assassination and for the privilege of giving the sex urge untrammelled sway". (p. 190.)

There is in the Mexican a genuine love of the land. The author pictures a Mexican peon mother trudging long miles over the desert to her "*tierra*" (the place of her birth and growing years) that she may give birth to her child in the same hut, even though it is now deserted.

There is also a sense of loyalty to the people and to the land among the upper classes. These and other precious things in the souls of the Mexicans can be seized upon by a properly organized educational system. Even a sublimation of the all-controlling sex instinct can be affected by a properly organized application of mental hygiene to the life of the growing Mexican child. Only by such educational applications of our knowledge of the development of character, personality, and citizenship can Mexico be saved to the Mexican.

The author points out the importance to the people of the United States of such education of these millions of Indians to the south of us. It is to our interest that they become socialized and organized and—may we say?—civilized. It is to our interest that they become honestly interested in themselves. Real self-interest should prompt us to study the psychology of this people, to set to work real educational forces among their children, and to secure their socialization.

THOMAS H. HAINES.

The National Committee for Mental Hygiene.

CASE STUDY POSSIBILITIES; A FORECAST. By Ada Eliot Sheffield.
Boston: Research Bureau on Social Case Work, 1922. 64 p.

Just at this particular stage in the development of mental hygiene, when the general public is reaching out, making demands, and expecting results that are frequently well beyond the limitations of our present-day knowledge, it is not surprising that in the effort to meet these requirements, quality of work is often sacrificed to quantity. We seek excuses for the hurried and superficial character of our work in the extensiveness of our labors; it is the number of hours of work and the number of cases interviewed by which many of us justify our existence. It is, therefore, gratifying to find in Mrs. Sheffield one who is not rushing madly on in the well-worn path of routine, but who is taking time to consider and to develop the possibilities in the task at hand.

Mrs. Sheffield's monograph is a real contribution. Within the limited space of 64 pages, she has dealt clearly and concisely with social case-work and its relation to the individual and to society. She has drawn from her experience the most valuable generalizations, and applied them to the individual with a skilled technique.

After discussing what she terms the "tentative rationale of analysis", in which she deals with the client's normal endowment and his social environment, she states frankly and unhesitatingly that the social point of view, as entertained by the social worker, "differs from that of most medical men, psychiatrists included, and from that of most practicing psychologists. These specialists, from the very nature of their training and their daily work, tend to take an anatomic view of the individual, to think of him more as a self-sufficient unit impinged upon by environmental forces than as an integral part of his social setting."

Those who spend much time in clinical work, regardless of its specific character, and who have been fortunate enough to have the assistance of a well-trained social worker, appreciate the fact that such a worker, by virtue of her social technique, is in a position to make a contribution that is invaluable both in diagnosis and treatment. It is of interest to those of us who are approaching many of our problems from a psychiatric point of view to know that the conviction that the personality of the client must be studied permeates Mrs. Sheffield's entire discussion. She appreciates keenly the necessity of making the same approach to medical social case-work that we have been laboring to introduce into the study of psychiatric cases. This will eventually mean that all social workers will be required to study the individual in the home, in the shop, at play, and at such times and places as the opportunity presents, that they may render to the psychiatrist the invaluable information obtained through these informal examinations.

The social worker has a unique opportunity to contribute to the problem of sociology. The author states that "as normal psychology has profited from the study of exaggerated mental states", so it is reasonable to suppose that sociology may "profit from the study of aberrations and failures in social adjustments".

Each page of Mrs. Sheffield's book has at least one paragraph that one would like to quote if space permitted. The monograph should be read by every one interested in social problems. It will undoubtedly stimulate more intensive study in case-work, which in turn should do much to establish the social worker on the professional plane to which she is entitled.

DOUGLAS A. THOM.

NOTES AND COMMENTS

Connecticut

A bill to establish a state psychiatric hospital is before the Connecticut legislature. By the terms of the bill, the state would make appropriations for the construction of the hospital and contribute toward its maintenance. Yale University plans to donate the land, which adjoins the New Haven General Hospital and the Yale School of Medicine. The new institution would be staffed by the General Hospital, of which it would be a unit, but Yale School of Medicine would have teaching privileges. This bill is the outcome of a survey made by the State Psychopathic Hospital Commission, which was appointed in 1921 by the governor, in compliance with an act of the legislature that year.

District of Columbia

An amendment to the War Risk Insurance Act was approved on March 4, 1923, providing that every officer and enlisted man or any person in active service under the War and Navy Departments who was discharged or resigned prior to the establishment of the Veterans' Bureau (August 9, 1921) and every such person in active service on or before November 11, 1918, who was discharged or resigned after the establishment of the Veterans' Bureau, shall be held to have been in sound condition when entering the service, except as to such disabilities as were recorded when or prior to the time he entered the service. This amendment also provides that an ex-service man who is shown to have a neuropsychiatric disease or an active tuberculous disease developing a 10 per cent degree of disability or more, and such showing was made upon examination by a medical officer of the Veterans' Bureau or by a legally qualified physician, within three years after his separation from the active military or naval service, shall be considered to have acquired his disability in such service or to have suffered an aggravation of a preëxisting neuropsychiatric disease or tuberculosis in such service.

The general appropriation act for the District of Columbia for the year ending June 30, 1924, authorizes the Board of Charities of the District to acquire a site for the new home and school for feeble-minded in the District of Columbia, Maryland, or Virginia. Not over \$38,000 is to be expended for the site. The authorization to use a

site already owned by the District, contained in the appropriation law for the fiscal year 1923, is repealed.

A bill introduced in the recent session of Congress to establish a department of public welfare for the District of Columbia failed of enactment. To this department would have been assigned the activities and duties of the Board of Charities, the Board of Children's Guardians, the trustees of the National Training School for Girls, and the directors of the Columbia Hospital for Women and Lying-In Asylum. In addition to the above-mentioned institutions, the department would have administered the Industrial Home School, the Workhouse of the District of Columbia, the Washington Asylum and Jail, the Reformatory of the District of Columbia, and the District Home and Training School. The work of the department would have been organized in four divisions—mental disease, child guardianship, corrections, and administration.

The department would have acted as commissioner of insanity, with power to investigate the question of the insanity and conditions of any patient in any institution for insane, public or private, within the District. All questions as to the sanity of inmates of penal, reformatory, and other institutions would have been referred to and determined by the department. It would have been authorized to encourage scientific investigations by the medical staffs of the various institutions and to publish bulletins and reports of scientific and clinical work done in these institutions. It would have had authority to establish and maintain free clinics for the feeble-minded, and maintain a registry of the feeble-minded. The measure gave in detail the procedure for court commitment of insane, feeble-minded, or epileptic persons. By the terms of this measure, the department would have developed psychopathic-hospital service by establishing and maintaining new hospital units and out-patient departments in connection with existing or future public hospitals.

Among other provisions of interest included in the bill were commitment for observation, emergency commitment, voluntary admission, and parole, a department for defective delinquents, the examination of prisoners under sentence in penal institutions alleged to be insane, and the licensing of institutions caring for insane, feeble-minded, and epileptic.

Illinois

A bill providing for a survey of specially handicapped children of school age is before the legislature of Illinois. Specially handicapped children are defined as follows: (1) children of school age who are three or more years retarded in school grades or those with the mental

equivalent of such retardation who have not had three years in school; (2) children of school age who are delinquent—displaying chronic truancy, lying, stealing, obscene talk and writing, sex offenses, anti-social tendencies, incorrigibility, and the like; and (3) children of school age who, in the opinion of the teachers, are different or stand out as being seclusive, asocial, melancholic, nervous, subject to fits or spasms or violent outbursts of temper, or suffering from physical or mental conditions of a nature to interfere with their own progress in school or with the progress of others or to render them disturbing factors to teacher or pupils. The survey would be conducted by the department of public welfare through its Institute for Juvenile Research.

A bill before the 1923 legislature would provide for the commitment of mental defectives with criminal propensities. This bill authorizes the state's attorney, before sentence is pronounced in criminal offenses, such as felony or misdemeanor, to ascertain whether the person has been previously convicted of felony or misdemeanor in this state or of felony in any other state. If, after such investigation, it appears that the person has been previously convicted, and the court believes that such person may be a mental defective, it shall be its duty to institute an examination of the person and his history to ascertain whether or not he is a mental defective. If there is reason to believe that he is mentally defective and a danger to the person or property of others, then a petition must be filed stating such belief, the facts upon which it is based, and the names and addresses of witnesses, and the court must be requested to order a mental examination of the person.

The judge may then order the accused person to be examined by a competent alienist, who is skilled in diagnosing mental disease and mental defect, and who shall have had at least five years' experience as a practicing physician. The examination is to be conducted privately. The alienist must certify to the court his findings in a signed report. If from this report and the evidence heard, the court is of the opinion that there is ground for believing the person to be a mental defective, then the court may order a copy of the report to be given to the state's attorney. It is his duty thereupon to file a petition for commitment to a state colony for the care of mental defectives or such other institution as may be provided by law.

This bill allows the accused person to present a defense and provides for the discharge of persons thus committed.

The following section is also found in this bill:

"Whenever a child under 17 years of age is brought before a juvenile court as a delinquent child only and it appears to the court that

such child is a mental defective as defined in this act, such court shall have the power and it shall be its duty to institute proceedings against such child in the same manner and to the same extent as is provided for in other cases under this act, and it shall be its duty if proceedings so justify to commit such child to a farm colony or other suitable institution as may be provided by law."

A bill requiring institutions that care for mentally defective persons,* or persons suffering from mental or nervous disorders, to obtain a license from the department of public welfare was introduced in the 1923 legislature.

Minnesota

A bill introduced March 1 would allow the state board of control to exercise general supervision over feeble-minded persons outside of institutions through any child-welfare board or other appropriate agency authorized by the state board of control. This bill would also provide for the release of feeble-minded persons to the care of relatives or friends under bond.

Missouri

A bill providing for the establishment of a separate state institution for epileptic persons was introduced in the 1923 legislature.

A bill before the legislature would provide for an increased number of assistant physicians at each of the four state hospitals for mental diseases and at the state institution for feeble-minded and epileptic.

Montana

The 1923 legislature of this state has enacted a law known as the "Eugenical Sterilization Law". It provides for a state board of eugenics composed of the chief physician of each custodial institution, the president of the state medical association, a woman member appointed by this association, and the secretary of the state board of health as chairman. This new board is to approve or disapprove the certificates for sterilization submitted to them by the chief physician of each custodial institution, and to review the decision of the chief physician in case of non-consent on the part of the guardian or relative. The board is empowered to exercise general supervision over matters pertaining to sterilization and over the chief physician and assistants in custodial institutions, and to require from them proper records and data for the determination of the efficiency, benefits, and specific effects of eugenical sterilization. The purposes of the bill are stated to be to better the physical, mental, neural, or psychic con-

dition of the inmate of any custodial institution, and to protect society. It is not intended to be a punitive measure.

Nebraska

A revision of the marriage law now before the legislature contains the following new provision: "No person who is afflicted with a venereal disease or who has been adjudged an imbecile or a feeble-minded person or a person who is or has been adjudged afflicted with hereditary epilepsy or hereditary insanity, shall marry in this state."

New Jersey

The state hospital at Morris Plains has opened a new 400-patient building which for the present will be used as a reception hospital. This hospital has received an appropriation of \$73,000 for the completion of a new sewage disposal plant, \$25,000 having been spent from last year's appropriations for this purpose. Other construction contemplated at this institution are a new power plant, two buildings for employees, and a new reception hospital of 100 beds for each sex, the present reception hospital to be used later as a treatment building. During the past year separate houses for the medical superintendent and clinical director have been built, as well as an apartment house for ten physicians, two two-family houses for physicians, and two cottages for nurses.

New York

A special message was recently sent to the legislature by Governor Smith urging the importance of submitting to the people for approval next autumn a bond issue of \$50,000,000 for the replacement of inadequate and inflammable buildings at the state hospitals and state charitable institutions with modern fireproof structures. A bill embodying the governor's recommendations has passed both houses of the legislature and awaits the governor's signature. The bond issue will be submitted to the voters at the next election.

The general appropriation bill that was passed by both houses on March 27 provides \$3,621,720 for new construction and permanent improvements at the state hospitals for mental diseases. The largest single appropriation in this amount is for continuing the construction of the new Creedmoor division of the Brooklyn State Hospital, \$800,000 being allowed for this purpose. Manhattan State Hospital receives \$615,000 for new construction, and the Marcy division of the Utica State Hospital receives \$375,000.

Increased amounts for personal service in the state hospitals have

been allowed, providing for a ratio of one ward attendant to every nine patients, except at the Brooklyn and Manhattan State Hospitals, where the ratio will be one to eight. Provision is also made for one physician to each 200 patients, excluding superintendents and pathologists, except at the Brooklyn State Hospital, where a ratio of one physician to 150 patients is allowed. The appropriation bill also provides for a chief occupational therapist at each state hospital and as many occupational-therapy aides as the state hospital commission shall approve. One social worker for each 100 patients on parole from urban hospitals and one to each 75 from rural hospitals are provided.

The four state schools for mental defectives will receive \$909,485 for new construction. The largest amount goes to Letchworth Village—\$580,000.

A bill providing \$1,500,000 for the construction of a special unit for ex-service men at Kings Park State Hospital has been signed by the governor.

An amendment to the education law, which will provide financial aid by the state to special classes in the public schools for mentally retarded children, has passed both houses of the legislature and is ready for the governor's signature. These classes were authorized by a law enacted in 1917 (summarized in MENTAL HYGIENE, July, 1917).

The text of the new provision is as follows:

"If the board of education of a city or union free school district establishes one or more special classes for the instruction of children who are three years or more retarded in mental development, as provided in this article, and shall employ one or more teachers for the instruction thereof, the commissioner of education shall apportion to such city or district, in the same manner as teachers' quotas are apportioned thereto, an amount equal to one-half the salary paid to each of such teachers, but not to exceed one thousand dollars for each teacher so employed. No such apportionment shall be made on account of a teacher so employed unless there shall have been issued to such teacher by the commissioner of education a certificate authorizing such teacher to teach such special classes or unless such teacher shall possess the qualifications prescribed by the commissioner of education."

Measures to reduce the number of state departments and to create a commission or commissioner on mental hygiene are now under consideration by the legislature.

North Dakota

A law enacted by the 1923 legislature that confers additional duties and powers upon the state board of administration authorizes this board to receive and provide for feeble-minded persons committed to its guardianship by courts of competent jurisdiction.

A bill to create a bureau of child research in connection with the departments of psychology and sociology of the state university failed of enactment. Its members would have been the professors and instructors in these departments, with a director appointed from among such members by the state board of administration. The duties of this bureau were thus defined in the bill:

"The bureau shall disseminate information relating to mental hygiene, the cause and prevention of insanity, mental defect, and epilepsy, and the effects of these on the individual, his or her offspring, the community, and the state; conduct studies of the relationship of mental disorders and epilepsy to crime and moral delinquency; conduct mental clinics in institutions for the feeble-minded, insane, and other public institutions, hospitals, and schools as may be determined by the bureau; make scientific investigation and research into abnormal and subnormal mental conditions and the clinical teaching of psychiatry, and into the treatment and prevention of delinquency, defectiveness, and dependency; conduct examinations of children or adults upon the order or request of courts or superintendents of institutions or agencies caring for dependent, neglected, defective, or delinquent children within the state, for the purpose of determining their mental condition and diagnosing their social conduct, and report the results of such examinations to the court, or other authority, requesting the same, and advise such court or authority as to the disposition to be made of the person examined; make mental tests or other mental examination of children, individually or in groups, in public schools of the state; and perform such other duties as may be imposed by law."

Washington

A eugenic marriage bill introduced in the 1923 legislature failed of enactment. This bill would have required the examination of all applicants for marriage licenses in regard to contagious or communicable venereal diseases and the mental fitness of such applicants to enter into a marriage contract as a condition to the issuance of a marriage license, except in the case of women forty-five years of age or older. If either or both applicants failed to pass the health and mental tests, one or both must have been rendered sterile before the

issuance of a license, and in no case would it have been issued if the certificate of examination showed a mental capacity of not over twelve years of age.

The examinations were to have been made by a regularly licensed physician competent to make such examinations. Unless the usual examinations showed positively the presence of communicable venereal disease or a mental capacity of not more than twelve years, a blood test would have been required. The regulations concerning these examinations would have been formulated and adopted by the state board of health. Any person would have had the right to appeal to the county court for a reexamination. This would have been made by a board consisting of three competent physicians or psychiatrists or both.

West Virginia

A bill to abolish the state normal school at Liberty and convert the buildings into a state educational school for the feebleminded was introduced in the 1923 legislature.

A state board of criminal supervision, consisting of five members—an alienist, a criminologist, a business man, a chaplain, and a superintendent of instruction—would be created by a bill before the 1923 legislature of West Virginia. To this board would be committed the length of sentence of every person sentenced to the penitentiary, and no person would be discharged except upon the order of the board, after being tested on parole.

Wisconsin

A bill before the 1923 legislature would extend the law requiring a physical examination as to the existence of any venereal disease of a person applying for a marriage license to include both sexes instead of only the male as formerly.

A MESSAGE FROM AUSTRALIA

The following remarks were delivered informally at the annual meeting of The National Committee for Mental Hygiene, last November, by Professor Elton Mayo, of the University of Queensland, Australia. The talk is of interest, not only for its account of the mental-hygiene movement in Australia, but for its humor and charm and its insight into the need for a broader conception of the function of education.

"I don't know if you are familiar in the United States with the famous incident in British history of the tailors of Tooley Street. Six tailors presented a petition to His Most Gracious Majesty the

King, and began it: 'We, the people of England'. I have as little right as those tailors to pose as a representative of Australian or British opinion on the subject of mental hygiene. I think that throughout the whole British Empire, and especially in Australia, we lack education in this to an extent that in the United States you hardly realize. Nevertheless, there are in Australia groups of people who are beginning to take interest in problems of this type. I have been actively associated with many medical practitioners, for example, in psychopathological work; these medical men are now definitely interested in mental hygiene by reason of our experience of its need. Groups of parents also are beginning to read and think on this subject in connection with the education of their children. They are no longer satisfied with the traditions of child training that have been handed down to them by the past generation. Large groups of teachers in Australia are doing their best to develop and extend this new parental interest. Remote though these individuals and groups may seem to be, they are, to an extent probably unsuspected by you, beginning to look out across the Pacific Ocean toward the work you are doing in this country. Here you are apparently more ready to experiment with a new idea than we are; it is perhaps this fact that recommends to us the work you are doing. Now these groups believe that this wide land of yours, self-sufficient though it seems to be, is in the first stages of an achievement that will yet bear fruit in our country and every other country in the world. In other words, we believe that although this is described as a national committee, the importance of its work is world-wide and its significance world-wide. The tendency in Australia to look across the Pacific towards America has increased and has been encouraged recently, not merely by the war—though collaboration between the medical forces of the Allies had, of course, its effect—but rather by the excellent work which the Rockefeller Foundation has been doing in a strictly medical way in Australia—work in infectious diseases, war against hookworm, and certain additional work in public health. The Rockefeller Foundation has made your methods well known in Australia and has inspired a very considerable respect for American investigation.

"Last year I heard one of the leading labor socialists of the commonwealth say (and I think what he said should be set down in your records): 'If in Australia we had men like the Rockefellers and the Carnegies, men of sufficient imagination to endow scientific research, then I, for one, would not believe that socialism was necessary. But', he added, 'we haven't got them in Australia and so far as I can see we are not likely to have them.' Whether he meant that we

haven't sufficient wealth in Australia or sufficient scientific interest, he did not make clear.

"Relatively little is being done at present in Australia in the field of mental hygiene. This is a sorry admission to make; I can only qualify it by adding that there is a desire to do something and that a deep interest in the whole question characterizes the leading men of the commonwealth. The head of the federal department of public health, Dr. Cumpston, keeps himself closely informed of the work of your National Committee. He is, I know, anxious to set on foot a similar movement in Australia. But he, and others like him, are faced with all sorts of difficulties. There is danger, for example, of public and political misunderstanding. In a country like Australia, it is not easy to keep suggestions of a mental-hygiene crusade free from 'political coloring'. Yet such a crusade must, of course, be clear of all political taint. Another difficulty is that the medical profession as a whole is not unanimous as to the form a mental-hygiene campaign should take. Several of the leading medical men of Australia have told me that they would welcome a visit from an American psychiatrist for educational purposes. I have every hope myself that such a visit will be arranged. It is a curious fact that in Australia, as in most other countries, if a man comes to settle with us, we tend to suspect his authority; if he comes as a visitor, we are willing to believe almost everything he says. For this reason, if for no other, I hope that Australia will shortly be visited by one of the well-known psychiatrists of this country.

"The services of such an educational visitor are greatly needed. In one of the Australian universities there is no instructor specialized to take charge of psychology. A student hears a few lectures on academic psychology in the course of several years of work. I understand from a leading psychiatrist that there are no lectures in psychiatry at all. This shows how deplorable the situation is in Australia. Dr. Ernest Jones, Director of Mental Hospitals in the State of Victoria, read a paper to the Australian Medical Congress of three years ago in which he based suggestions as to what should be done on the methods adopted at Albany in the state of New York. Certain pious resolutions were carried by the congress, but no action has followed. In a sparsely populated country personal factors enter largely into politics; he who seeks to extend the sphere of activity of his professional group is apt to be suspected of hidden motives.

"But the Australian horizon is not altogether dark; certain recent events give ground for hope to those interested in mental hygiene. Sir John MacPherson, formerly First Commissioner of Lunacy in Scotland, has been appointed to the chair of psychiatry in the Univer-

sity of Sydney for a period of three years. In that time he will, no doubt, survey and reorganize the work of the university and of the state department. Recently also there has been appointed to the University of Queensland a psychiatrist of high standing, formerly assistant to Dr. C. S. Myers of the University of Cambridge. Dr. Lowson has had extensive neurological, psychiatric, and psychological experience during the war, and before it; his chair is entitled a 'research chair in medical and educational psychology'. It is an unusual type of university appointment in that lecturing and teaching are not required of the occupant of the chair. Those things are made definitely secondary to research.

"These two appointments mean much to Australia, but they do not complete all that may be said for the future of psychological and psychiatric work. As I said at the beginning of my address, it is the rising interest in the Australian public attitude to mental hygiene that will assure the necessary backing for any movement. Recently there has been an immense flood of psychopathological literature—some of it very bad, some of it interesting and instructive. Those who take an intelligent interest in the education of children are reading these books to an extent that one cannot readily realize. The outcome is that there is no longer a general assumption that any sort of mental disorder is necessarily beyond remedy. This greater hopefulness has been strongly reinforced by the work of psychiatrists in military hospitals. The Red Cross Society of New South Wales, during the latter stages of the war, endowed four hospitals for 'shell-shock' cases and nervous disorders. These were the Russell Lea Hospital at Fine Dock, Sydney, the Novar Hospital for alcoholics, and two country hospitals at Exeter and Mowbray Park. Although intended primarily for the treatment of war conditions and 'shell shock', these hospitals soon discovered other mental conditions in returned soldiers which responded to psychopathological treatment. Consequently, whereas in former days there was no place to send an individual suffering from mental trouble except to an asylum—in which case one usually gave up hope—it was now possible for the relatives of soldier patients to send them to Russell Lea for preliminary examination and treatment. Among a great many cases thus admitted to Russell Lea, there were an unexpected number of recoveries. This became known to the general public and reinforced the general belief, the growing belief, that all was not well with our pre-war methods of handling mental and 'nervous' disorders. Recently a movement has begun to take form amongst parents and educators, a movement which asks not merely for assistance in respect of defectives and the neurotic, but asks that skilled advice may be made

available for parents and teachers. The traditional methods of education no longer command our undivided allegiance; we no longer accept blindly the tradition of family discipline committed to us so complacently by a former generation. There is a growing public desire to substitute understanding and skill for mere tradition. This is leading to a move in the direction of organized mental hygiene.

"I think this attitude gives hope for the organization of this work outside the United States and especially when we read in your report the assertions of your representative in Canada. I believe that the British dominions would respond readily and generously at the present moment to an appeal for the organization of a mental-hygiene movement. Everywhere the field is ripe for work, so far as I know the field. The misfortune is that in many places workers are few and charlatans are finding the less intelligent members of the public an easy prey. It seems to me a very great pity that it is not possible for the medical profession to take hold of a field such as that which offers for this work in Australia—before the charlatan begins his systematic exploitation of the credulous.

"I have only one other thing to say. Several speakers here to-day have advised you to push beyond mere mental hygiene as at present conceived and to take into consideration the whole system of education. I hope you will not hesitate to follow their advice. Your present work implies a criticism of educational methods, a criticism that should be pushed home. Education, as usually understood, takes no account of the part played by reverie in the development of the individual. Yet every day shows with greater clearness that the individual is determined to success or failure, to happiness or misery, far more by the reveries of infancy and adolescence than by any other factor in his educational career. Systems of education very generally neglect this important and fundamental fact. I remember a phrase in a Greek classic which describes the mental exaltation of a youthful reverie. The literal translation is: 'I tread on air and gaze upon the sun.' What description could be finer? But the official school translation was, and is: 'My wits are woolgathering.' In that phrase you have expressed the whole attitude of the educational system to this most important psychological fact—the reverie that does more to educate the individual than all the 'concentration' forced upon him by our social, professional, and commercial training. I hope that in the development of your activities, you will not hesitate to turn back to the educational system, when need arises—and that you will express with clearness and vigor your criticism of our present methods of training the young."

PSYCHIATRIC SECTION OF THE AMERICAN ASSOCIATION OF HOSPITAL
SOCIAL WORKERS

Psychiatric social workers throughout the country have organized as a section of the American Association of Hospital Social Workers, to be called the Section on Psychiatric Social Work. This action, discussed and planned at the time of the National Conference of Social Work in Milwaukee, 1921, was put into effect during the 1922 conference at Providence, when the American Association of Hospital Social Workers at its annual meeting formally adopted the section. The active membership of this association includes any one who has been employed for a year in social work in a hospital or dispensary. As many psychiatric social workers are employed in clinics not connected with hospitals and dispensaries or in mental-hygiene societies, provision is made for admitting associate members of the association to active membership in the section, when they meet the section's membership requirements.

The requirements for active membership in the section are based upon training and experience; there are no associate members. Graduates of recognized training courses in psychiatric social work of not less than nine months' duration are eligible after they have held a position in psychiatric social work for one year; graduates of schools of social work who have not taken a special course are eligible after two years in a position in psychiatric social work; and persons who have not taken formal training, but who meet certain educational requirements, are eligible after four years of successful accomplishment in psychiatric social work.

The objects of the section are stated as (1) to promote association among psychiatric social workers and (2) to maintain standards in psychiatric social work. Various local groups that meet more or less informally are coöperating with the section. No local branches of the section, however, are being formed at present, as the emphasis is now upon uniting all eligible psychiatric social workers of the United States and Canada in one organization. News of the progress of the new section will appear in the association's bulletin, and meetings will be held when the association holds its annual meeting during the Conference of Social Work in Washington, May 16 to 23.

The term "psychiatric social worker" was first used about 1918 to indicate a social worker working in association with a psychiatrist in the study and care of persons who present psychiatric problems. Such problems may appear as mental disease, delinquency, antisocial behavior, or bad habits, and in so far as all social workers meet these problems, some knowledge of psychiatry is essential to all social case-work. But there arose a need for a specially trained social worker,

with a dominant interest in mental processes and mental hygiene, to work with the psychiatrist. In 1918, there were perhaps fifty social workers in the United States engaged in this field, who had received their preparation in various ways. During this year two special courses of training for psychiatric social work were started, one by the Smith College School of Social Work and the other by the New York School of Social Work. Previously the only systematic training offered for this special field had been an apprentice course given by the social service of the Boston Psychopathic Hospital. Since 1918, a number of courses have been offered in various places and others are under discussion. The demand for social workers in this field has been so great that many who were trained for other branches of social work have been drawn into it, sometimes with a short preliminary course of study or a short period of apprentice training and sometimes without even this slight preparation. In many places, particularly in connection with work for ex-service men, it has been necessary to use the services of persons who have some knowledge of mental disorders, but have had no training in social work. Because of this variety in personnel, there is considerable variation in the standards for psychiatric social work held by different persons, but in the main the standards set by the two schools of social work that first introduced this special training are being upheld and advanced. These schools require for admission a previous education of college rank and give a course of approximately two years, including practice in social case-work for at least nine months. A curriculum for a course in psychiatric social work is recommended in the report of the Committee on Training for Hospital Social Work of the American Hospital Association, which worked during the year 1921-1922 under the chairmanship of Michael M. Davis, Jr., upon an investigation of the subject of training for medical social work and psychiatric social work.

The officers of the new Section on Psychiatric Social Work of the American Association of Hospital Social Workers are as follows: Mary C. Jarrett, President, Boston; Mary Ferguson, Vice-president, Philadelphia; Maida H. Solomon, Secretary-Treasurer, Boston. Other members of the executive committee are: Marie Donohoe, Boston; Cornelia Hopkins, Chicago; Susie Lyons, Boston; Martha Strong, New York.

Inquiries of all kinds may be addressed to the secretary, Mrs. H. C. Solomon, 74 Fenwood Road, Boston, Massachusetts.

REPORT OF CONSULTANTS ON HOSPITALIZATION¹

The report of the consultants appointed by the Secretary of the Treasury to advise him in providing the hospital facilities for disabled ex-service men authorized by Public Act 384 two years ago, when \$18,600,000 was appropriated for this purpose, contains an interesting record of what has probably been the most extensive work undertaken in the field of hospitalization by the government in time of peace. This work represented the first constructive attempt to deal with a problem that has occupied the public attention conspicuously during the past three or four years and has by no means yet been solved. While the consultants deserve great credit for the accomplishment of a difficult task, their work is open to serious criticism in one respect. The needs of general medical, surgical, and tuberculous cases have been well met, except with reference to the geographic convenience of certain sites, but those of the mental and nervous cases have not received a proportionate amount of attention. A striking difference is shown by the report between the policy that inspired the work in behalf of ex-service men disabled by tuberculosis and that which governed provision for those suffering from mental and nervous diseases. The one has been characterized by adherence to the fundamental principle that disabled ex-soldiers should be cared for in special government-operated hospitals, while the other has reflected no such ideal. According to the latest report of the United States Veterans' Bureau, 43 per cent of the more than 9,000 neuropsychiatric patients under government supervision are still in "contract" institutions, while but 24 per cent of the 11,000 tuberculous patients are thus placed. In harmony with this policy of non-provision, the suggestion is made that the beds vacated in the National Soldiers' Homes for Disabled Volunteers by the death of Civil War veterans be utilized for mental patients as they become available in the future, but it has been pointed out by the experts who have testified at Congressional hearings and on other occasions that these patients require highly specialized care and that the mere existence of a number of beds without special equipment and trained personnel does not constitute adequate hospital provision. One hundred vacancies created in this way in a branch of the National Soldiers' Home would be about as valuable for one hundred mental patients as they would for the same number of babies so far as special facilities are concerned. The estimate, on page 34 of the consultants' report, of the number of neuropsychiatric patients who will require hospital care at the "peak of the load" differs from that of expert psychiatric opinion by

¹ For a review of this report, see pages 412-17 of this issue of **MENTAL HYGIENE**.

3,000 to 4,000 beds. The "peak" has evidently been passed with regard to the tuberculous and general medical cases, but the weekly reports of the Veterans' Bureau point to a constantly increasing number of mental cases. The impression given by the consultants' report, and widely spread by newspaper abstracts, that there is danger of overhospitalization for mental patients is at variance with the facts. The fear is expressed that "there will be a greater number of hospitals than can be utilized for the purpose for which they were built", but this can hardly be applied to those that have not yet been built, but are still urgently needed for the mentally disabled and will be used for many years to come by the residual group of young and relatively able-bodied men who will make up the larger part of the burden of the "peak of the load". On the contrary, the long-continued nature of much mental illness makes it necessary to differentiate with regard to the problem of future use, which in this case is a very remote one, and emphasizes all the more the importance of providing government-operated hospitals. Failure to recognize this principle only results in greater hardships to the class of ex-service men which has already suffered most and can least afford to bear additional burdens.

A COMPREHENSIVE LIST OF SCIENTIFIC PERIODICALS

The Conjoint Board of Scientific Societies of Great Britain is preparing to issue a list of all scientific periodicals that contain the results of original research, together with information as to the libraries in Great Britain at which they may be consulted. No complete list has ever been made of these thousands of periodicals, written in many languages and printed all over the world. Many of them may never reach England, it is stated, and those that do are scattered in libraries here and there throughout the country. The trustees of the British Museum have allowed the staff of the keeper of printed books to undertake the preparation of the list, and material for it has been sent in by many libraries and scientific societies. It is hoped that it will be printed before the end of the year. Between 300 and 400 copies, at a price of \$10 each, have already been subscribed for as a result of the preliminary announcement.

CURRENT BIBLIOGRAPHY *

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The National Committee for Mental Hygiene

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